**CHARITY NO: 1104951**
**COMPANY NO: 5176998**

# BOARD OF DIRECTORS – PART ONE

## MEETING IN PUBLIC

Tuesday 26 July 2022 at 9.30 am

Microsoft Teams and Meeting Room 9 St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG

| | | Info / Dec | LEAD | | Page No. | Timing |
|---|---|---|---|---|---|---|
| **1.** | Welcome and Apologies | Information | Paul Burstow | | *3* | *09.30* |
| **Administration** | | | | | | |
| **2.** | Declarations of Interest | Information | Paul Burstow | | *4* | *09.31* |
| **3.** | Minutes from the Board of Directors Meeting in Public on 27 May 2022 | Decision | Paul Burstow | ✓ | *5-16* | *09.32* |
| **4.** | Action Log and Matters Arising | Information & Decision | Paul Burstow | ✓ | *17-19* | *09.35* |
| **Chair's Update** | | | | | | |
| **5.** | Chair Update | Information | Paul Burstow | | *20* | *09.40* |
| **Executive Update** | | | | | | |
| **6.** | CEO Report | Assurance | Oliver Shanley | ✓ | *21-31* | *09.45* |
| **Committee Assurance Reports** | | | | | | |
| **7.** | **Committee Updates**<br>• Quality & Safety Committee (14/06), incorporating:<br>  ○ Complaints Annual Report<br>  ○ Mortality Surveillance (Annual) Report<br>  ○ Infection and Prevention Control (Annual) Report<br>• Audit & Risk Committee (21/07), incorporating:<br>  ○ Caldicott Guardian & SIRO Annual Report<br>• Pension Trustees (07/07) | Assurance & Decision<br><br><br><br><br><br>Assurance<br><br>Assurance | David Sallah<br><br><br><br><br><br>Elena Lokteva<br><br>Martin Kersey | ✓<br><br><br><br><br><br>✓<br><br>✓ | *32*<br>*33-35*<br><br>*36-62*<br>*63-66*<br>*67-90*<br><br>*91-94*<br><br>*95* | *10.00* |
| **8.** | Governance Oversight Group update | Assurance | John Clarke (Mel Duncan) | ✓ | *96-109* | *10.35* |
| **Quality** | | | | | | |
| **9.** | CQC Inspection, Report and Actions Update | Assurance | Andy Brogan | ✓ | *110-113* | *10.40* |
| **10.** | Safer Staffing Report | Assurance | Andy Brogan | ✓ | *114-133* | *10.55* |
| **Break 11.10 am to 11.20 am** | | | | | | |
| **Regulatory** | | | | | | |
| **11.** | Modern Slavery Act renewal | Decision | Martin Kersey | ✓ | *134-136* | *11.20* |

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| **Assurance** | | | | | | |
| **12.** | Board Assurance Framework | Assurance & Decision | Duncan Long | ✓ | *137-181* | *11.25* |
| **Operations** | | | | | | |
| **13.** | Integrated Quality & Performance Report, incorporating:<br>• Quality Scorecard<br>• People Scorecard<br>• Finance Overview<br>• IT Security Overview | Assurance | Anna Williams, Kevin Mulhearn & John Clarke | ✓ | *182-205* | *11.40* |
| **Topics for Discussion** | | | | | | |
| **14.** | Divisional Presentation (including patient voice): Birmingham – Video | Information | Kerry-Ann Chinn and Patient | | *206* | *12.05* |
| **15.** | Divisional Presentations – looking ahead | Review & Comment | Duncan Long | ✓ | *207-209* | *12.30* |
| **Any Other Business** | | | | | | |
| **16.** | Questions from the Public for the Board | Information | Paul Burstow | | *210* | *12.35* |
| **17.** | Any Other Urgent Business (notified to the Chair prior to the meeting) | Information | Paul Burstow | | *211* | *12.40* |
| **18.** | Meeting reflections | Information | Paul Burstow | | *212* | *12.45* |
| **19.** | Date of Next Meeting – Thursday 29th September 2022 | Information | Paul Burstow | | *213* | *12.50* |
| **Meeting Closes at 12.50 pm** | | | | | | |

# Welcome and Apologies

(Paul Burstow – Verbal)

# Declarations of Interest

(Paul Burstow – Verbal)

# Draft Minutes from the Board of Directors Meeting in Public on 27 May 2022

(Paul Burstow)

**CHARITY NO: 1104951**
**COMPANY NO: 5176998**

**ST ANDREW'S HEALTHCARE**

**BOARD OF DIRECTORS**
**MEETING IN PUBLIC**

**Conference Room, Main Building,**
**St Andrew's Healthcare, Northampton**

**Friday 27 May 2022 at 09.30 am**

| Present: | |
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| Paul Burstow (PB) | Chair, Non-Executive Director |
| Stuart Richmond-Watson (SRW) | Non-Executive Director |
| Ruth Bagley (RB) | Non-Executive Director |
| Elena Lokteva (EL) | Non-Executive Director |
| Stanton Newman (SN) | Non-Executive Director |
| David Sallah (DS) | Non-Executive Director |
| Jess Lievesley (JL) | Interim Chief Executive Officer |
| Kevin Mulhearn (KM) | Interim Chief Finance Officer |
| Andy Brogan (AB) | Chief Nurse |
| Sanjith Kamath (SK) | Executive Medical Director |
| Martin Kersey (MK) | Executive HR Director |
| **In Attendance:** | |
| John Clarke (JC) | Chief Information Officer |
| Rupert Perry (RP) | Lead Governor |
| Alex Trigg (AT) | Director of Estates and Facilities |
| Oliver Shanley (OS) | Advisor to the Board |
| Julie Shepherd (JS) | Improvement Director |
| Duncan Long (DL) | Company Secretary |
| Anna Williams (AW) | Director of Performance |
| Cat Vichare (CV) Item 14 | Clinical Director |
| Melanie Duncan (Minutes) | Board Secretary |
| **Apologies Received:** | |
| Andrew Lee (AL) | Non-Executive Director |

| Agenda Item No | | Owner | Deadline |
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| 1. | **Welcome**<br>PB (Chair) welcomed everyone to the first part of the Board of Directors (Board) meeting, which is a meeting open to attendance by the public. Apologies received from Andrew Lee were noted. | | |
| **ADMINISTRATION** | | | |
| 2. | **Declarations Of Interest & Quoracy**<br>Members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose.<br><br>PB declared an interest regarding Essex and Community Partnerships, relating to his Chair position at Hertfordshire and West Essex ICS.<br><br>OS declared that he was in attendance in his capacity as Special Advisor to the Board.<br><br>The meeting was declared quorate. | | |

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| **3.** | **Minutes Of The Board Of Directors Meeting, held in public, on 24 March 2022**<br>The minutes of the meeting held on the 24 March 2022 were **AGREED** as an accurate reflection of the discussion. | **DECISION** | |
| **4.** | **Action Log & Matters Arising**<br>It was agreed to keep **OPEN** the two actions on the log:<br><br>• 24.03.22 **01 –** Staff Retention Metrics<br>The action was re-assigned to MK, with the update being that work was ongoing with NHFT. Metrics were not currently in place, as they were being developed.<br>• 24.03.22 **02 –** Governance Update – Authority Matrix<br>It was noted that the Matrix would be presented for approval at the Board in July. | **DECISION** | |
| **CHAIR'S UPDATE** | | | |
| **5.** | **Chair Update**<br>PB gave his update to the Board, beginning with the annual update on the Fit and Proper Persons Declarations. These were **NOTED**, with no material disclosures made.<br><br>The Board **NOTED** and **AGREED** the Disclosures<br><br>PB then updated verbally, noting the recent recruitment and appointment process for both the new CEO; who will join in August with an announcement anticipated in the coming two weeks; and the new COO who has been recruited from the NHS with good experience.<br><br>PB further updated that DS would be leaving the Board of Directors in the Summer. PB thanked DS for his input on quality and safety and for his leadership during his time with the Charity. PB confirmed that the recruitment of a further 2 Non-Executive Directors is now underway.<br><br>PB, JL and OS had met with NHSEI in March to discuss the concerns with regards to Women's Services and the changes in charity leadership. Assurance was provided within the meeting as a result of the discussions. Quality continued to be placed highly on all agendas in recent weeks, with it being noted that Quality and Safety Committee would be kept appraised regularly by People Committee.<br><br>PB then extended his thanks and appreciation to JL who would be leaving the Charity in the coming weeks. JL's leadership of the organisation was acknowledged, along with how JL had helped the Board to understand the challenges faced by the Charity.<br><br>The Board **NOTED** the update. | **DECISION** | |
| **EXECUTIVE UPDATE** | | | |
| **6.** | **CEO's Report**<br>JL presented his report which was taken as read, thanked PB and the Board for their kind words and acknowledged the privilege that it had been to adopt the position of CEO and thanked the Executive team for their support. JL added that the direction that the Charity should take was now clear and that it would aid with continuous improvement.<br><br>JL highlighted the recent re-inspection of Women's Services which had concluded. No matters for escalation had been noted, and the draft report was expected in the first week of June. A Board update would follow.<br><br>With regard to workforce, the Allocate implementation would be due to take place in June, which would result in matching resources with acuity. A period of testing was imminent, with a further update due to be made to the Board once the Executive have agreed the go or no-go scenario. JL further explained | | |

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| | that workforce deployment and how teams worked together had been a focus. Recruitment was a challenge with retention also now becoming a major focus. The culture change programme would also help to address these areas.<br><br>Meetings with banks had been held relating to the Revolving Credit Facility (RCF), with good feedback given. Options were now awaited, with relationships with one or more banks expected.<br><br>SN thanked JL for his tenure and enquired regarding the PREMHS item included in the report, asking what was the frequency and response and if the results could be benchmarked against other Trusts. JL responded and requested that the items be discussed further during the IQPR section of the Agenda. SN also asked about culture and if there was a timeline for the discovery phase of the project. JL replied that the discovery phase was due to end in July, to be closely followed by the Action Phase with implementation in the Autumn.<br><br>DS also thanked JL and asked what the purpose was for the culture interviews due to be held in the coming weeks. DS also wanted to know what the process was for those returning to work after long term sickness. JL replied that the culture interviews had been used successfully in other Trusts and demonstrated that contact with leadership showed understanding of everyone's priorities. MK replied that with regard to sickness, there were 217 members of staff who had been away from work for more than 3 months. 197 of these people were now back in work, as many of the cases were Covid related. Sick pay had substantially reduced as a result, with the conversations having an effect. PB added that the NED interviews for Lead the Change would begin on the Monday and would be a chance to articulate what the Board was trying to achieve. MK outlined the sessions that were planned with the Change Champions. PB noted that partial assurance was offered with regard to sickness absence and that further work continued for the long term.<br><br>RB noted that cost efficiency and opportunities to reduce costs in the current climate should be considered by the Board. JL agreed with RB and suggested the ESG group and their work which could align accordingly.<br><br>The Board **NOTED** the update | | |
| **7.** | **Committee Assurance Reports**<br><br>***Quality & Safety Committee***<br>DS presented the report and outlined the 3 most significant issues which had been discussed by the Committee:<br>• CAMHS Staffing<br>• Safeguarding Level 3 Training<br>• Impact of delayed transfers of care<br>DS also highlighted the Quality Account page turning exercise which had happened the previous day, noting that the report would be submitted for approval by Board in the coming weeks.<br><br>The Board **NOTED** the report<br><br>***Audit & Risk Committee***<br>EL presented the report and outlined the highlights and discussions from the most recent meeting:<br>• The transfer to the new external auditors, Grant Thornton was working to plan.<br>• Operational Risks had been discussed<br>• A new Material Risk relating to the RCF had been raised<br>• One Material Risk relating to Estates had been retired<br>• Internal Audit presented their report on the DSPT Toolkit<br>• Accounting Policies, Internal Audit and the Local Counter Fraud annual plans were all approved. | | |

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| | The Charity Risk Appetite had also been approved, following development using Good Governance guidelines, with links to the results of the E&Y governance review. This work would assist in articulating the risk appetite for adoption across the Charity. ARC also recommended endorsement of the Risk Appetite Strategy. JL agreed, adding that this would give a good framework for balancing risks across the organisation. EL added that ARC had requested regular reporting on the Risk Appetite.<br><br>PB asked if the timeline for full assurance on significant risks was ready. EL noted that how this was approached and what the measurement of success was. A 12 month timeline was given. PB added that risk appetite needed to be embedded by both the Board and the Executive Team, and asked if the risk strategy conveyed the correct level of risk relating to Therapeutic Risk. EL confirmed that this had been discussed in detail at the previous meeting. SK added that particular phraseology could be used in order to reflect the complexity and probability of the risk. RB added that communication throughout the whole organisation would be required with regard to well thought out therapeutic risk. SN commented that regulatory compliance wording as used by Research and Innovation could be used for consistency. AB noted that risk appetite should also cover clinical risk, with the Board setting the tone. The Change Leader programme would help with this, and encourage with the broader approach. PB added that the recent incidents within CAMHS reflected the challenge of taking appropriate therapeutic risk, with DS also commenting that patient and staff safety were central to the risk appetite strategy.<br><br>The Board **APPROVED** the Risk Appetite Strategy subject to further focus on therapeutic risk and compliance. PB added that a Board session on these areas would be required. DL to schedule.<br><br>The Board **NOTED** the report<br><br>***Research Committee***<br>SN presented the update which was taken as read, noting that the Research Strategy had been approved by the committee and was also being presented for consideration by the Board later in the meeting. Research Committee also presented a proposal for a further operational research group to be formed. SN also updated that Paul Wallang had left the Charity, with thanks being extended for his work.<br><br>The Board **NOTED** the report<br><br>***Pension Trustees***<br>SRW presented the update which was taken as read. There were no further questions.<br><br>The Board **NOTED** the report<br><br>***People Committee***<br>PB presented the update which was taken as read, noting the following key issues which had been discussed by the Committee:<br>• Sickness Absence<br>• Workforce challenges deep dive<br>• Recruitment and Retention<br>RB noted that the data regarding non-patient facing shifts appeared to be out of sync. JL explained that there was a culture in the way in which the organisation used and deployed staff, and outlined what level of non-patient facing shifts were acceptable. He added that Allocate would be critical in addressing existing practices, with an anticipated 2,000 shifts being able to be re-deployed every month as a result.<br>PB added that the strategy and IQPR measures of success had also been considered.<br><br>The Board **NOTED** the report | **DL** | **04.11.22** |

| Quality | | | |
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| 8. | **CQC Inspection, Report and Actions Update**<br>AB presented the paper which was taken as read, and noted that the many of the actions raised as a result of the inspection were closed, however, a substantial amount remained open, due to a high level of assurance being required. AB commented that he was confident that the work within Women's Services had led to significant improvements in care.<br><br>DS asked if the report should have been presented to QSC prior to the Board, in order to provide the requisite assurance, and what measures had been taken as a result. AB replied that the report had been presented to QSC at previous meetings, and that direct feedback from the regulator had indicated that improvements had been observed, that safeguarding alerts had reduced and that improvement measurements had been observed with evidence in place.<br><br>JL commented on the QIP and subsequent learning noting that this stemmed from setting high standards, with the evidence and structures in place to close actions far in excess of what was being observed elsewhere in the region. JL added that a more pragmatic approach was needed for gaining assurance when closing the actions. JL also noted that JS would challenge if the correct practices were not observed.<br><br>JS agreed, and suggested that simpler forms of evidence should be considered when reviewing quality improvement action plans and confirmed that NHFT had also gone through the same process and that much simpler evidence would be used in order to provide assurance.<br><br>The Board **NOTED** the report | | |
| 9. | **Quality Improvement System Support and Buddying Workstreams Update.**<br>AB and JS presented the paper which was taken as read. JS noted that the paper outlined the support that had been extended via the buddy relationship, and wished to thank everyone for their help and welcome at the organisation. JS then outlined the nature of the relationship and the work that had been done since October the previous year, and highlighted that funding discussions were ongoing for the coming year. PB thanked JS for her support and that of NHFT.<br><br>RB noted the biggest risks mentioned in the paper and asked if there was a mechanism in place for continued support and embedding. AB acknowledged the risks, adding that recognition of them was important, with the recruitment of the Quality Matrons to enforce and embed an important factor. Performance reporting has helped enormously, along with the governance structure in place. AB noted that this work needed to remain on the agenda for the time being.<br><br>RB further commented that cultural leadership and staff resistance was of great importance and needed to be addressed. AB replied by outlining the 6Cs work by Vishelle Kamath, with some resistance being observed, which was now fast becoming a legacy following support from HR. Future recruitment to the Charity's values will be important in order to retain this culture. JS agreed, noting that St Andrew's was a focus both regionally and nationally, and that documenting the journey would be important. She added that the CQC report was a good indicator of progress.<br><br>DS commented that the buddy forum had worked well and that from a QSC perspective, the work on the Quality Account indicated connection and engagement.<br><br>JL noted that this was a significant piece of work which was as a result of how the leadership had positioned the organisation, with the Charity now embracing its position within the system. JL added that the banks were now noticing how unique the process is as well. The biggest risk would be sustainability, with the longer term operation now in focus. SK reiterated sustainability with proactivity | | |

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| | now being the focus. The process was already underway with the benefits already being seen. SK further added that the work in Women's Services was not done in isolation, but that all divisions were part of the process and the subsequent benefits, with continuous engagement now important<br><br>OS thanked JS for her report and noted the importance of governance and culture along with quality improvement. He noted that alignment of these was paramount, with the senior leaders being operationally bound in the short term, however, that was not sustainable.<br><br>PB summarised by thanking JS and her team at NHFT, noting the mutual benefits that the arrangement had brought. PB asked QSC to review and provide assurances to the Board with regard to the level of assurance needed for the closure of actions along with the sustainability of the programme and its embedding within the Charity, with People Committee to provide assurance with regard to talent management, retention and culture.<br><br>The Board **NOTED** the update. | **DS & AB**<br><br>**PB & MK** | **29.09.22**<br><br>**29.09.22** |
| **10.** | **Safer Staffing Report**<br>AB presented the report which was taken as read, and noted the detailed narrative within the report which covered the changes in ASD/LD figures due to the flexing down on planned numbers; Essex having the largest gap with regard to qualified nurses to establishment and no action cards being instigated in Essex. AB highlighted the CAMHS wards which were experiencing challenges, with staff consistency being paramount where there was high acuity. AB drew the Board's attention to the improvement process that had been introduced as a result. Stabilisation would be key with staff being moved into the division for the coming months.<br><br>AB added that the issues within the division were also being actively discussed with system partners, and that NHSE visiting the division. Meetings had been scheduled with the CAMHS Collaborative to discuss the pressures on the service. A further detailed report on CAMHS was being presented at the next QSC.<br><br>PB thanked those members of staff who had written to him with regard to the service but asked why the Freedom to Speak Up Guardians had not been used. AB noted that as issues needed to be identified early on, this was not ideal. However, a lead Freedom to Speak Up Guardian had been appointed and would be highly visible within CAMHS.<br><br>JS offered to link the Guardians up with those within NHFT and liaise on mandatory training. JS also stated at this point that there was a potential conflict regarding this, as NHFT was a commissioning partner, which the Board noted.<br><br>JL added that no staffing issues were raised with the Guardians, however, other issues had been noted. He added that within the East Midlands, all organisations were experiencing the same challenge with investment currently being made into community based settings as opposed to in-patient based services, but was confident that the work being done would address the issues.<br><br>SN noted concern regarding the timeline prior to the next QSC and wanted to understand refusals to deploy. AB replied that a further briefing would be made available to QSC members in due course. With regard to refusals, these remained a concern, especially with regard to cancelled shifts. AB agreed to include data on this in future reports.<br><br>SK confirmed that this was an area of focus, along with addressing skill mix; particularly where there are specialities to take into consideration; this would be tackled by Allocate. JS confirmed that this also formed part of NHFT's previous challenges. SN suggested that this be included as part of the work being done on culture. | **AB** | **29.09.22** |

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| | RB asked who was responsible for those patients awaiting transfer, and where did the liability sit. AB replied that it was the commissioner's responsibility with regard to placement, but that it was our liability whilst the patient was in our care. RB then noted that mitigation was required for this and asked if thought was being given to longer term solutions. AB commented that this was being addressed and would update RB offline.<br><br>RB then commented that it was good to see no clinical action cards, and asked if the approach should be reviewed in the medium term. DS noted that redeployment of staff would require them to have specific skill sets, and also wanted to have a better understanding of the Guardians; he agreed that these areas would be discussed in more detail at the next QSC. SK confirmed that staff are being moved (redeployed) already, with EL noting that as a result of Neuro's recently improving, could these principles be applied within CAMHS. AB confirmed that they could and that changes led by the clinical teams had been successful.<br><br>SRW asked if the new staffing rota had been a success. AB confirmed that it had, with the language around the system now being changed. A review on the lesson learned and other aspects was imminent. KM confirmed that financially, the initiative had been implemented with little or no financial impact as a result of transition. AB confirmed that an evaluation would be conducted.<br><br>PB summarised by acknowledging the work being done, and noting the following assurances expected from Committees:<br>• Assurance from People Committee regarding actions being taken to address refusals to re-deploy, specifically in relation to the work being done on the Charity's culture<br>• Assurance from QSC with regard to robust arrangements with Freedom to Speak Up Guardians, and if there are any additional steps needed to be taken.<br>PB also acknowledged the serious pressures nationally with regard to secure CAMHS.<br><br>The Board **NOTED** the update | **PB & MK**<br><br>**DS & AB** | **29.09.22**<br><br>**29.09.22** |
| **Finance** | | | |
| **11.** | **NHS Improvement Annual Solvency Commitment**<br>KM presented the paper which was taken as read.<br><br>The Annual Commitment was **APPROVED** by the Board | **DECISION** | |
| **Assurance** | | | |
| **12.** | **Board Assurance Framework (BAF)**<br>DL presented the paper which was taken as read, noting that this work was a continuance of the improvements in the Charity's Risk Management system and the BAF links the Strategic Risks to the existing system and to the Charity Strategy.<br><br>AB wanted to make sure that there was a distinction between material risks and those included within the BAF. DL replied by explaining the differences and that the material risks were linked to the strategic risks and vice versa, however the design of the system removed duplication of processes.<br><br>SN noted concerns regarding the strategic risks and felt that the 8 quoted were quite restrictive. He also asked if the Board would receive an overview of what was being reviewed by the Committees at least annually. DL replied that in excess of 150 strategic milestones are included within the Charity Strategy and that these are monitored via the milestone tracker process managed by Eddie Short, Director of Strategy and that the tracker would support the reporting of strategy progress to the Board. Longer term risks, such as relating to the | | |

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| | Research or Education strategies would be managed via the operational and material risk route, moving to strategic as they increase in priority and impact.<br><br>The Board will receive a BAF update at every meeting, with Sub-Committees completing periodic reviews of the areas within the BAF under their remits. The new BAF process will be formally reviewed in January once it has been reported a number of times to allow for any changes required, and once confirmed will move to an annual review in conjunction with a review of the Charity Strategy.<br><br>OS commented that it was helpful that the 8 strategic risks were all aligned. PB added that a review in January would address the embedding phase.<br><br>The Board **AGREED** to adopt the framework, and would revisit it in July, following its review at ARC. | **DECISION** | |
| **Operations** | | | |
| **13.** | **Integrated Quality & Performance Report**<br>AW presented the report which was taken as read, and highlighted the additional quality metric that has been added, along with the sustained improvement seen in the existing metrics, with no concerns at a Charity level. AW also highlighted how disaggregation would provide greater clarity within certain metrics, however there are some minor concerns when these are broken down to a divisional level. The mitigations for these concerns were included in the report and AW confirmed that assurance is provided to the Board through the governance approach, performance framework and the detailed presentation provided to the QSC.<br><br>SK then presented the MyVoice dashboard and highlighted the uptake of the survey across the Charity. He then outlined the benchmarking process which had been used during the development of the survey. SN thanked SK and asked why a bespoke system had been used. SK explained that there was not an industry standard available, with differing services using differing settings. Friends and Family was a common test, however, others were more specific. SN then asked if Community Services used the survey. It was confirmed that Community Partnerships do use the survey, with other metrics used as well as there were concerns that there was no comparability within that area. PB then asked if there was anything that could be done across the Midlands provider collaboratives in order to improve benchmarking data. SK replied that contact had been made with other Trusts in order to benchmark against similar provisions.<br><br>EL noted that the use of agency staff had reduced, and asked if the target could be stretched, and if we had benchmarked against absence levels. MK replied that agency usage used to be at 15%, however, there were now challenges with sourcing staff from this area, but that it was being addressed. With regard to absence levels, this was not currently benchmarked. AB added that the PREMS data was the first quality priority within the Quality Account.<br><br>PB enquired with regard to assurances on the work being undertaken on delayed transfers of care, especially on admissions and discharges. SK replied that the admissions process was currently being refined, with the data being scrutinised, and would be addressed once Allocate had been delivered. SK agreed to prepare a paper on Delayed Transfers of Care for presentation to QSC with more detailed analysis on the area and information on where we have some control within the system and where we do not.<br><br>KM highlighted the financial overview, noting the end of year position and further noted the forward view where the trend continued to be favourable to budget. There had been an increase in occupancy in April, with the trend expected to continue from a cost perspective. Easing of restrictions had helped with this increase. | **SK** | **14.06.22** |

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| | EL asked about staff increases in relation to increases in bed occupancy and at what point would this be seen. MK outlined how the gap was being managed on a weekly basis. EL then asked if the registered nurse levels could be overlaid on the bed occupancy graph in order to view potential correlations. AW agreed to look at the data.<br><br>SN asked for further information on non-operating costs. KM outlined the investment portfolio, which showed an adverse trend which could be linked to the current situation within the Ukraine. SN then asked what percentage was bed occupancy versus other sources of income. KM replied that 94 – 95% of income was generated by bed occupancy.<br><br>The Board **NOTED** the report | **AW** | **26.07.22** |
| **Patient / Carer Voice** | | | |
| **14.** | **Divisional Presentation – Community Partnerships**<br>CV joined the meeting and gave a presentation on the division and the different areas in which it operated.<br><br>DS congratulated CV on the recent rating received from the CQC and asked if there was an opportunity to offer the service in the Birmingham area, suggesting that opening dialogue with the local Council may be beneficial. CV agreed that there was an opportunity and that they had been approached about doing some assessment work.<br><br>SN asked if the IT issues experienced the previous year had been resolved. CV replied that they had been, and that RiO was now being used by the service, with an outcomes dashboard being worked on. SN then noted that the business to business opportunities highlighted in the presentation appeared to be attractive, and asked if CV required any support in this area. CV explained that these opportunities were direct enquiries received locally, and would link them in with the Business Development Manager once they were in post. SN then asked about staffing levels within the division, and if there were acceptable. CV replied that they were not currently an issue as the division was flexible in the way in which it worked.<br><br>RB asked if there was a register of local authorities who had also pledged to the Armed Services Covenant, as the service could be promoted within those towns. RB further offered her assistance in making contact if this was the case.<br><br>AB noted that some contracts were comparatively small and short term, and asked how this could be addressed and supported. CV replied that working with business development would help with further developing this area.<br><br>MK commented that the service user experiences were good to see. CV replied that they were working with Bobbie Kelly to nominate HeadFest for a HSJ award.<br><br>PB thanked CV, and asked how the CQC rating had been received within the division. CV replied that whilst some areas were frustrating, work was underway internally and with the regulator in order to ascertain what needed to be done to attain outstanding, ensuring that we build on where we are and do not fall back anywhere.<br><br>The Board **NOTED** the presentation | | |
| **Matters Arising / Discussion Topic** | | | |
| **15.** | **Research Strategy and Strategy Implementation Plan**<br>SN presented the paper which was taken as read, highlighting that it was in two parts. Firstly the strategy itself, which had been approved by the Executive Team and then secondly, the implementation plan. | | |

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| | JC asked how benchmarking was being used, with reference to the KPI list. SN replied that it was difficult to gain comparable data as some Trusts invested heavily in research, whilst others did not.<br><br>DS commented on how pleased he was to see the inclusion of research activity which will result in patient benefit by 2026, and what the financial returns would be from this activity. SN replied that the intention was to place the Charity on the same basis as NHS Trusts as far as costs and research were concerned, which will mean a financial return for each piece of research. SK further noted that bespoke arrangements will need to be in place for each contract in the future, in order to gain reputational benefit and grant income.<br><br>RB raised the risk of diversion of capacity for the department and how this could affect the implementation of the strategy, and the resultant costs involved. RB also noted that further development of the financial aspects would be beneficial as well as noting what the current financial commitment was. SN replied that all the staffing would be new, and not existing Charity staff, with the resultant costs mitigated by clinical time.<br><br>JL commented that phasing of the strategy needed to be considered as this element was not considered to be a priority for the next 2 years. He added that there were funds available to support for the first 2 years of the strategy, however, after that point, the department would be required to be self-funded. KM added that there were existing grants that were being drawn on and would be considered further at the correct time. SN clarified that the expectation was that the department would eventually be self-sustaining. SK commented that the reputational gains would be worth the investment as the themes were aligned with the Charity.<br><br>AT asked about geographical locations highlighted in the SWOT analysis and how these would impact the strategy. SN replied that the location of universities was important and the majority are a little distance away and whilst manageable, proximity is important.<br><br>MK commented on the table which indicated the number of conferences, and asked where the Trauma Centre featured. He added that there were opportunities to move towards the model that was currently being used by Dr Morris. SN replied that conferences were important from a reputational perspective, to inform people that you are interested in a certain area and from a financial perspective SN added that he agrees with the model being used by Dr Morris and links to the model he has previously suggested, whereby clinical and research work is mixed.<br><br>DS added that in his opinion, research was a long term process and if we adopt the strategy correctly it will benefit the Charity.<br><br>PB summarised by proposing that the Board approve the strategy as the basis for setting the Charity direction for research and that the implementation plan be approved subject to further work on the financial plans, timings and phasing and the use of any seed funding.<br><br>The Board **APPROVED** the strategy, and **APPROVED** the implementation plan subject to further work on the financial aspects. | **DECISION** | |

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|---|---|---|---|
| **Regulatory** | | | |
| **16.** | **Data Security & Protection Toolkit (DSPT) – Pre-submission Approval**<br>JC presented the annual submission for approval, noting that Internal Audit had given adequate assurance, along with there being re-validation of ISO 27001 in the current year. JC added that all standards had been met.<br><br>The Board **APPROVED** the submission | **DECISION** | |
| **ANY OTHER BUSINESS** | | | |
| **17.** | **Questions from the Public for the Board**<br>No questions were received for the Board. | | |
| **18.** | **Any Other Urgent Business (notified to the Chair prior to the meeting)**<br>There was no other Business notified. | | |
| **19.** | **Date of Next Meeting :**<br>Board of Directors, Meeting in Public – Tuesday 26th July 2022 | | |

**Approved – 27th May 2022**

**……**
**Paul Burstow**
**Chair**

# Action Log and Matters Arising

(Paul Burstow)

## St Andrew's Healthcare Board of Directors MEETING IN PUBLIC Session Action List:

| Meeting in Public | ACTION | Owner | Deadline | Open / Closed | STATUS |
|---|---|---|---|---|---|
| 24.03.22 **01** | **Safe Retention metrics** JL agreed to speak to Julie Shepherd, Improvement Director with regard to staff retention metrics being used within NHFT as part of the culture model, and would share accordingly. | MK | ~~27.05.22~~ 26.07.22 | Open | **27.05.22** – Reassigned to MK from JL - Work was ongoing with NHFT. Metrics were not currently in place, as they were being developed. **26.07.22** - Julie Shepherd, Chief Nurse at NHFT has confirmed that the HR KPI's metrics are being reviewed across the East Midlands Alliance and an update will be provided towards the end of 2022. **Propose action is delegated to the People Committee for any further action to be taken.** |
| 24.03.22 **02** | **Governance update – Authority Matrix** Following the presentation of the new Charity Authority Matrix, it was agreed that it would be circulated to the Board for further consideration and feedback. Once collated, the Matrix was to return to Board for decision and approval. | KM | ~~27.05.22~~ 29.09.22 | Open | **27.05.22** – (MD Update) Meeting arranged KM/MD on 22nd June. Matrix to be considered as part of the Governance Project. Matrix is being developed and is under review. **26.07.22** - Matrix remains under review and is to be presented for approval at the Board in September. |
| 26.05.22 **01** | **Risk Appetite – Board Awareness** Following the approval of the Charity Risk Appetite, Board awareness sessions are to be scheduled on Therapeutic risk and compliance. | DL | 04.11.22 | Open | **26.07.22:** Remains open and due at November meeting |

| | | | | | |
|---|---|---|---|---|---|
| 26.05.22 **02** | **Quality Improvement – QSC Assurance**<br>The QSC are requested to review and provide assurance to the Board on the level of assurance needed for the closure of actions along with the sustainability of the Quality Improvement (Buddying) Programme and its embedding within the Charity. | DS & AB | 29.09.22 | Open | **26.07.22:** Assurance report is provided at each QSC. Will be part of QSC Assurance report to Board going forward from September.<br>Remains open and due at September meeting. |
| 26.05.22 **03** | **Quality Improvement – People Committee Assurance**<br>In relation to the Quality Improvement (Buddying) Programme, the People Committee are requested to provide assurance to the Board on talent management, retention and culture. | PB & MK | 29.09.22 | Open | **26.07.22:** Remains open and due at September meeting |
| 26.05.22 **04** | **Safer staffing – refusals data**<br>AB to include data on refusals to deploy in future safer staffing reports. | AB | 29.09.22 | Open | **26.07.22:** Remains open and due at September meeting |
| 26.05.22 **05** | **Safer staffing – QSC Assurance**<br>The QSC are requested to review and provide assurance to the Board on the robustness of arrangements with Freedom to Speak Up Guardians, and if there are any additional steps needed to be taken. | DS & AB | 29.09.22 | Open | **26.07.22:** Remains open and due at September meeting |
| 26.05.22 **06** | **Safer staffing – People Committee Assurance**<br>The People Committee are requested to review and provide assurance to the Board on actions being taken to address refusals to re-deploy, specifically in relation to the work being done on the Charity's culture. | PB & MK | 29.09.22 | Open | **26.07.22:** Remains open and due at September meeting |
| 26.05.22 **07** | **Delayed Transfers of Care QSC update**<br>SK to present a detailed paper on Delayed Transfers of Care at the next QSC, with more detailed analysis on the area and information on where we have some control within the system and where we do not. | SK | 14.06.22 | **Close** | **26.07.22:** Detailed paper presented to QSC at 14th June meeting.<br>**Propose action is closed** |
| 26.05.22 **08** | **Integrated Performance Report – Registered Nurse levels**<br>AW to look at how registered nurse levels could be overlaid on the bed occupancy graph within the IQPR in order to view potential correlations. | AW | 26.07.22 | Open | **26.07.22:** The recruitment projections are in the process of being reforecast – these will be shared with the People Committee in August & the requested overlay presented in September Board. |

# Chair Update

(Paul Burstow – Verbal)

# Paper for Board of Directors

| | |
|---|---|
| **Topic** | CEO Board Update |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **6** |
| **Author** | Professor Oliver Shanley OBE, Interim CEO |
| **Responsible Executive** | Professor Oliver Shanley OBE, Interim CEO |
| **Discussed at Previous Board Meeting** | Updates have been discussed at the Executive meetings. |
| **Patient and Carer Involvement** | A number of these items would have been discussed with patients and carers |
| **Staff Involvement** | |
| **Report Purpose** | Review and comment ☐<br>Information ☒<br>Decision or Approval ☐<br>Assurance ☐ |
| **Key Lines Of Enquiry:** | **S** ☒ **E** ☒ **C** ☒ **R** ☒ **W** ☒ |
| **Strategic Priority Area** | Education and Training ☒<br>Finance & Sustainability ☒<br>Service Innovation ☒<br>Quality ☒<br>Research & Innovation ☒<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☒ |
| **Committee meetings where this item has been considered** | |

**Report Summary and Key Points to Note**

The attached is the Chief Executive's report to the July Board of Directors.

**Appendices -**

# CEO Report

This is the CEO report to the Board of Directors to provide information on a range of topics germane to the effective running of the Charity, providing an update on areas of focus for the Executive Committee over the last reporting period and matters that are not dealt with under other agenda items for the Board.

## 1. National update

This section provides members with some information about new national policies or guidance that are influencing the shape of key partners notably our provider and commissioning colleagues. It is written to ensure that Board members are aware of the national context that the Charity operates within and informs the Charities strategy.

***Draft Guidance on good governance and collaboration and Draft Code of governance for NHS provider trusts.***

In May the NHS published 2 key consultation documents regarding the governance of NHS provider organisations. These are relevant in that they affirm how NHS providers must position themselves in light of the changing NHS landscape.

They identify some key points that emphasise the importance of working through Integrated Care systems and an expectation for collaboration across organisational boundaries. These include;

- The success of individual NHS trusts and foundation trusts will increasingly be judged against their contribution to the objectives of the integrated care system, in addition to their existing duties to deliver safe, effective care, and effective use of resources.

- This guidance sets expectations of providers in terms of collaboration in respect of three key areas – engaging consistently in shared planning and decision making, consistently take collective responsibility with partners for delivery of services across various footprints including system and place, and consistently taking responsibility for delivery of agreed system improvements and decisions.

From July 2022 Integrated Care Board will, through the new Health and Care Bill 2022, remove legal barriers to collaboration and integrated care, making it easier for providers to use their knowledge and experience to take on greater responsibility for service planning and putting integrated care systems (ICSs) on a statutory footing.

The reports remind readers that better health and care and a reduction in health inequalities for populations across England will be delivered by providers working collaboratively as part of system and place-based partnerships and provider collaboratives. Effective collaboration requires system-minded leadership – recognising that trusts and other health and care organisations together are the system – and strong working relationships between partners to develop shared objectives and ensure their delivery. This must be underpinned by organisational and individual behaviours which create the right environment for collaborative change. Importantly these principles broadly reflect the Charities strategy.

***Eliminating Inappropriate Out of Area Placements in Mental Health. Royal College of Psychiatrist (June 2022)***

In June the Royal College of Psychiatrists published a report regarding placing patients outside of their local area. The report sets out how the long-term commitment to improve the accessibility and quality of mental health services across the country has been very welcome. It states how progress has been variable, and the government's deadline to eliminate inappropriate out of area placements for adult acute patients by the end of March 2021 has now been missed by a full year. The report comments on how patients are sometimes hundreds of miles away from home, they are unable to access their usual support networks while at their most vulnerable, often finding their care seriously disrupted with long term implications for their recovery.

The report affirms that some ICS areas have been able to keep occupancy rates closer to the recommended threshold, but still struggle with high numbers of inappropriate out of area placements. Aside from high occupancy rates in inpatient services, the report cites that capacity constraints in community and crisis services can also result in inappropriate out of area placements. Patients who might otherwise not need an inpatient admission but for whom no specialist intensive provision exists locally can also be sent out of area. The report gives one example of this as people with learning disabilities and autism.

The document also reminds readers that it is hugely costly to the health service, sending a patient to a unit in another service is far more expensive than admitting a patient to a locally commissioned bed. In addition to the fact that patients in out of area placements often spend longer in hospitals, this means that the NHS has spent more than £102 million on inappropriate out of area placements in the year to March 2022.

The report makes a number of recommendations for leaders to consider, they include

- Systems to conduct service capacity assessments and target investment towards services driving inappropriate out of area placements locally

- Make inappropriate out of area placements a key performance indicator for new Integrated Care Boards to monitor progress and respond rapidly to changes in demand and supply.

- Ensure all providers consistently report monthly OAP data to NHS Digital to enable data-driven and targeted support for local areas struggling and the identification of best practice

***Children and Young People's Mental Health Services GIRFT Programme National Specialty Report***

A recently published report by the 'Getting It Right First Time ' programme shows that Children and Young People's Mental Health Services (CYPMHS) is the fastest growing area of healthcare across the country with resulting increases in resources. This report is important for the Charity as it provides a further evidence base regarding the need for children services.

There are a multitude of national drivers and programmes to ensure the resource for children mental health is targeted, valued and effective. Significant changes in the commissioning arrangements are taking place through the NHS-led provider

collaborative programme. The Getting It Right First Time (GIRFT) report looks to support and enhance these national programmes, while allowing a clearer focus in identifying unwarranted variation or improvement requirements in unexpected or unexplained areas.

There is vast variation within CYP services, in part due to the number of commissioners within the field and the differing priorities in different areas of the country. The report suggest that there is certainly no clear best or worst model, but the Five Year Forward View for Mental Health dashboard shows that there is wide variation in Clinical Commissioning Group (CCG) spend and access to community services.

In 2019, data the mental health dashboard showed almost 40% of the total CYPMHS budget was spent on the approximately 4,000 young people admitted to an inpatient unit. Additionally, the average cost of one admission would support almost 100 young people within the community for one year. The report cites that despite this imbalance in spend, for too long an admission into an adolescent inpatient unit has been driven by a lack of appropriate community services rather than the belief that it is the best-known treatment.

The report, sets out a number of actions including the development of more efficient alternatives to admission, joint working, restrictive practice, reducing the need for long admissions for young people and the use of digital assessments for which St Andrews was cited as an example of best practice for the use of technology through video conferencing.

A number of recommendations are made in response to the findings including;

- There must be a clear strategy and plan on reducing the proportion of young people remaining on the inpatient until for more than 60 days.

- Clear therapeutic models must be present on each unit, concordant with available NICE guidance, for the most common reasons for admissions. The model requires identified clinical interventions including frequency, intensity and expected outcomes. These models should be accurately staffed and link to the funding model for the unit.

- A blended model of commissioning for inpatient units should be considered and commissioned based on the provision of therapeutic models and outcomes, not a cost per bed day model.

- All provider organisations must focus on reducing the incidence of restraint, prone restraint, and seclusion and should:

    - Ensure levels of restraint in the CYP inpatient population are no higher than in the adult inpatient population
    - Have a clear plan in place to reduce incidents of restraint and seclusion. Improvement activity should be based on benchmarking with peers aiming for milestones year on year to achieve a position in the top decile

- Commissioners must ensure that young people are admitted within their natural clinical flow, recognising that there may be patient choice or specific clinical needs to admit outside. This should be in line with the national CYPMH Competency Framework.

**Call for evidence for new 10-year plan to improve mental health**

The Department for Health and Social Care (DHSC) started a national consultation on the development of a new national 10 year Mental Health Strategy in April. The plan will build on current progress, assessing how local services can work together to prevent mental ill health.

The DHSC set out how the general public, people of all ages with lived experience of mental health conditions and those who support people with mental ill-health are urged to respond to a 12-week call for evidence . This seeks to inform a new 10-year mental health plan and a refreshed national suicide prevention plan seeking views on what can be improved within the current service, particularly in light of the pandemic which has led to record levels of people seeking treatment.

The call for evidence aims to add to the understanding of the causes of mental ill-health, listening to people who have interacted with services and those who know and support them, to draw on 'what works'. This will support the development of a plan which aims to prevent and mitigate the impacts of risk factors on mental health and suicide, particularly for groups who experience disparities.

The 10-year plan builds on the NHS Long Term plan and forms part of the government's wider commitments to 'build back fairer', working towards putting mental health on a level footing with physical health, and forms a key part of the commitments to address health disparities across the country and to improve the mental wellbeing of the nation.

St Andrews approach to developing our response has been built around the engagement of patients, service users and colleagues in co-produced conversations discussing the questions outlined in the consultation.

This has enabled sharing of perspectives from the experience of those 'roles' but also more broadly as citizens and users, or future users, of health and care services. These responses have been supplemented by views and ideas of colleagues who have contributed through an email channel and wider conversations. A copy of our submission can be located here https://www.stah.org/assets/St-Andrews-Healthcare-submission-for-DHSC-10-year-plan.pdf

***Draft Mental Health Bill 2022***

On Monday 27 June the government published the draft Mental Health Bill (and explanatory notes), which will now undergo pre-legislative scrutiny. The Bill follows the 2021 white paper, Reforming the Mental Health Act, and Sir Simon Wessely's 2018 independent review of how to modernise the Mental Health Act 1983. I understand the Bill will be introduced to parliament early next year at the earliest, following a period of pre-legislative scrutiny, and royal assent is expected later in 2023/24

The reforms in the mental health act are considered to be long overdue and largely welcomed. The changes should offer better support to patients, care for more people in the community and better meet the needs of people with a learning disability and people with autism.

The Bill is wide ranging and includes the following key points;

- The introduction of four new guiding principles, increasing the frequency of automatic referrals to the mental health tribunal, and the creation of the nominated person statutory role.

- The four new guiding principles are: choice and autonomy – ensuring service users' views and choices are respected; least restriction – ensuring the MHA powers are used in the least restrictive way; therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the MHA; and the person, as an individual, – ensuring patients are viewed and treated as individuals

- Autism and learning disability –These provisions seek to limit the detention of people with a learning disability and/or autistic people under the Act where there is no co-occurring mental health condition. They also introduce duties on Integrated Care Boards (ICBs) to improve understanding of risk of crisis amongst these groups of individuals and to improve the supply of community services to prevent inappropriate detentions.

- Appropriate medical treatment - This includes a new requirement that, when considering whether medical treatment under the Act is "appropriate" for a patient, consideration must be given to whether there is a reasonable prospect that the outcome of the treatment would have a therapeutic benefit. A new definition of "appropriate medical treatment" is also set out.

- Nominated persons –These clauses introduce a new statutory role – the nominated person – to replace the nearest relative currently referred to in the 1983 Act. This will enable service users to select who represents them

In response to the proposals the MH Law Steering Group will consider the material changes as set out in the guidance document and the time lines for adoption across the Charity.

## 2. Quality

- **CQC update**
  The CQC recently undertook a re-inspection of the Northampton Women's and Men's services and we are waiting for the draft reports. The initial feedback was positive, with recognition of the improvements seen. It was also commented that all of the Must Do actions had been addressed. On receipt of these reports we will review the relevant quality improvement plans to continue to drive the required changes. The CQC have also undertaken an inspection of the Essex site, and whilst recognising improvements since the previous inspection a few years ago, they raised some specific concerns regarding the model of care on the rehab ward and some concerns about documentation. This is being reviewed and a robust response and action plan is being formulated.

  We are currently in the process of re-registering the Northampton site as a single registered service, with the divisions being recognised as core services. This is in conjunction with, and support of the CQC.

- **CAMHS**
  Board members will be aware that following internal concerns in relation to workforce resilience and upward trending of incidents, it was agreed to pause admissions and institute a rapid improvement process in the CAMHS Division. Following a number of

potential safeguarding allegations, the CAMHS Provider Collaborative called a Risk Summit and sought assurance from the Charity that we had plans in place to safeguard our patients in CAMHS, and to develop a Quality Improvement Plan that would resolve the current issues. The plan was presented to the Executives and a second meeting with the collaborative held on 9 June. The plan was shared and discussed further at the Charity's Quality and Safety Committee on 14 June to provide assurance that we had implemented a process to address the concerns identified internally and shared with the Provider Collaborative.

The service is still enabling patients to progress with their recovery and the young people in our care are on track for discharge as planned. There is strong support from the wider Charity to drive the improvements set out within the Quality Improvement Plan, which will continue to benefit from direct Executive oversight until the measures required are in place and sustained. In the most recent meeting with partners feedback was positive and the Clinical and Managerial lead indicated they were assured that the action plan was progressing well and noted the progress with safeguarding, training, and staffing. They have indicated we will have a further meeting in six weeks, where if progress continues, we will jointly consider lifting the restrictions to admissions.

- **HSIB and what it means for St Andrew's**
  The Health Safety Investigation Board HSIB published a report into safety issues in LD/ASD services on 24 June. The Board is a national body and investigates safety issues that may have implications for health care organisations.

  The aim is not to identify individual institutions but to make recommendations for wider safety changes across healthcare. In summary, the issues identified are around missed medication, the competencies of MH nurse working in LD and physical layout of clinic rooms. There are a number of national and local recommendations.

  The report made 5 recommendations; two for national bodies and three related to providers of services:

  - It may be beneficial if electronic prescribing and medicines administration (ePMA) systems were interoperable with electronic patient records (EPR) systems to allow details of medicines omissions to be alerted to staff automatically from the ePMA system to the EPR system.

  - Safety observation O/2022/173: It may be beneficial if user menus on electronic prescribing and medicines administration (ePMA) systems provided clear differences and reasoning for the categories used to record medicines omissions.

  - It may be beneficial if organisations that use mental health nurses to cover shortages of registered learning disability nurses review their clinical model and conduct a training needs analysis. The aim of this would be to identify skills or training requirements, to make sure mental health nurses have the relevant communication methods and strategies to assist patients with learning disabilities in taking their medication

  We will take the full report and action plan to the next QSC.

## 3. People

- **Lead the Change**
  The Lead the Change Programme is nearing the end of the discovery phase with our 3rd workshop on 7 July with the objective to 'To identify the initial list of work streams to address the issues from the discovery phase'. In the previous workshop Change Leaders spent some time thinking about any 'quick wins' that can be implemented quickly and would have an impact on staff experience

  Overall, the discovery phase has included the Change Leaders reviewing our current data, holding 80+ staff discussion groups, interviewing the Board and gathering patient and carer feedback. We continue to gather feedback from patient and carers and this element of the discovery phase will continue into July. The focus areas in July are:

  - Implement the quick wins identified
  - Change Leaders reviewing our initial work streams and choosing an area they are interested in or where they have expertise
  - Agreeing the timeline and roll out of the culture survey and input from our Change Leaders and Ash Roychowdhury, Deputy EMD
  - Planning the design phase of the programme

- **Acclamation from University of Northampton**
  We have undergone a thorough re-validation and approval process for our partnership with the University of Northampton.

  This re-validation enables us to continue to deliver a range of HE programmes in collaboration with the University and lays the foundation for growth for our projects in developing Master level programmes, supporting international students, and importantly continuing our ASPIRE programmes where we support individuals to become registered nurses.

  We received four commendations:

  - Celebrating our close working relationships and common values between UoN and St Andrews in creating public benefit throughout Northamptonshire
  - Our creative and proactive curriculum design which anticipates skills needed for the future and includes co-production
  - Our commitment in ensuring inclusive access to learning, regardless of educational background
  - Our people/learner centred approach; where students felt listened to and valued

## 4. Finance

- **Qtr1 2022/23 Finance performance**
  The Charity reported a £2.2m deficit for the quarter ending 30 June 2022 and this is £0.5m better than budgeted. 97% of the budgeted income was achieved (reflecting lower occupancy than budget) but this was offset by lower costs. Some of the

occupancy/income shortfall to budget relates to the self-imposed admissions to the CAHMS Division

- **2022/23 Financial outlook**
  The Executive Committee have completed a high level financial forecast and conclude that the current expectation is that the 2022/23 financial year budgeted net deficit position of £2.4m will be achieved. Qtr1 trends will continue into Qtr2 with occupancy/income falling below budget but offset by lower costs. From Qtr3 budgeted occupancy levels are expected to be achieved.

- **Credit Facility Refinance update**
  Work continues with the banks and at the time of writing the position continues to progress. Chief Finance Officer will provide full update at the Board meeting.

- **External stakeholders**
  NHSI continue to meet monthly with the Charity but the financial performance over the last four years of sizeable losses and reduced cash flow is a cause for concern. In response we have jointly agreed with NHSI to commission an Independent Business Review of St Andrews. The scope of work has been agreed in collaboration with NHSI/St Andrews and we expect the review to be completed in September 2022 and report available in October 2022. This will help the Charity ensure we can maintain and improve financial stability and meet the aspirations of our strategy.

## 5. Communications and engagement

- **Lightbulb programme wins award**
  Cheryl Smith, Headteacher of St Andrew's College within our Child and Adolescent Mental Health Service (CAMHS), has scooped a top award for her prevention work within mental health and education.

  Cheryl picked up the Community Changemaker of the Year prize at the annual Changemaker Awards ceremony, hosted by the University of Northampton (UON). Now in its sixth year, the awards programme recognises people, services and organisations that make a positive social impact created through their changemaking activities.

  Cheryl was recognised at the glitzy event, held at the Park Inn Hotel, for launching the LightBulb programme, which has been designed to help teachers spot the early signs of mental health issues in children and then take appropriate, early action.

  LightBulb provides a ready-made framework for schools so those that participate can demonstrate and showcase excellence regarding mental health practice, to regulatory bodies such as Ofsted.

  Once signed up, the school receives mental health awareness and support training for all school staff as well as sessions for parents and students. Each session talks about symptoms, support and signposts resources.

  Since LightBulb was launched in 2021, the programme has been delivered at 32 schools and reached more than 11,500 children. The LightBulb team are now looking at how they can take the programme to a national level

- **PRIDE event**
  On Wednesday 15 June, patients and staff in Northampton took part in a Pride march through the grounds. Colourful clothing and accessories were encouraged and participants enjoyed an afternoon in the sunshine as they marched to demonstrate their freedom to be truly who they are. The event was a joyous occasion where LGBTQ+ patients, staff, and their allies could gather to celebrate what it means to be a part of the LGBTQ+ community at St Andrew's.

  Sarah Ward-Greef, co-chair of PRIDE, our employee network, said: "It was heart-warming to see so many patients and staff coming together to celebrate Pride and what they have in common. St Andrew's is home to all kinds of people and that really was evident today."

- **Patient party**
  The Northampton patient party was held on 12 July, and included a BBQ, music and other activities, patients were encouraged to get creative and take part in a cupcake decorating competition

- **Carers week**
  From 6-12 June we celebrated Carers Week, which aims to make carers visible, valued and supported. Throughout the week we shared information on how we can all support the carers of our patients to be our partners in care. The week included a variety of drop-in sessions, events, and stories which focussed on the benefits of working closely with carers, the work of our Carers Centre team, and the support we can offer staff members who are carers outside of the workplace.

- **Staff party**
  Staff from all our sites were invited to our staff party held on 14 July on our Northampton site, the evening included a live band, a BBQ, cocktails and games. Food and the first drink were free for all attendees.

- **Word from the Ward**
  We are celebrating our staff members "excellence, commitment and passion" in a brand new film series being shared on our social media channels. Word from the Ward has been developed to put our staff in the starring role so they can showcase what they do when at work.

  It is hoped the series, which will be released on a weekly basis, will boost recruitment and demystify what we do here at St Andrew's.

  To watch the videos, follow us on social media:
  - Twitter: @StAndrewsCare
  - Facebook: @STAHealthcare
  - Instagram: @standrewscare
  - LinkedIn: St Andrew's Healthcare

- **Annual awards ceremony**
  Our Annual Awards event took place on Monday 30 May at the Park Inn, Northampton, we're pleased to share that the ceremony was a wonderful success. Attendees were able to enjoy a three course lunch and reception, and celebrate the incredible work and dedication of our finalists and winners:

  - Compassion winner - Silverstone Ward
  - Accountability winner - Denmark Chikowe

- Respect winner – Adam Jardine
- Excellence winner – Cheryl Smith
- Inspirational Individual winner - Tom Bodkin
- Outstanding Achievement winner - Alexei Titievskii
- Carers' Champion winner - Fairbairn Ward
- Making a Difference winner - Skye Nkala
- Anne Ford Volunteering Award winner - Roger Brewer
- Team / Ward of the Year winner - Stowe Ward
- One Charity Award winner - Central Absence Team
- One Charity Award winner - Kronos Response Teams
- Charity Executive Committee Award winner - Community Partnerships Team

- **Freedom to Speak Up Guardians – drop in sessions**
  Our Freedom to Speak up Guardians offer a confidential and effective way for staff to seek support and guidance on anything that gets in the way of them doing a great job.

  Our Lead Guardian, Laura Dorrington is holding a series of drop-in sessions throughout June and July to meet with staff and discuss how the team can help with any issues or concerns.

- **Recent media coverage**
  Nearly 170,000 people have read stories about St Andrew's throughout June, including pieces on our new CEO, the return of the podcast and our continued partnership with the University of Northampton.

  June kicked off with the announcement that Dr Vivienne McVey has been appointed as our new CEO, which was covered in both the physical newspaper and online of the Chronicle and Echo website and Laing Buisson News.

  Consultant Clinical Psychologist Dr Inga Stewart made her column debut in the Chronicle and Echo, and Integrative Psychotherapist Liz Ritchie once again made it into national press, talking to Glamour magazine about normative discontent and what it really means.

  The Chronicle and Echo also ran a story about us winning a prize at the Northampton Film Festival; this story also appeared on Northants Live.

  A few days later the Chronicle also published the announcement that the On the Ward podcast was making a comeback and Gillian Momi, part of the dietician team at St Andrew's Healthcare, had a column published in the paper to mark National Dietician Week.

  The month of the summer solstice wrapped up with the news that the University of Northampton and St Andrew's Healthcare are continuing their partnership which involves nurses getting on the job training. The story was published in the following publications: Daily Business Now, Wellbeing News, UKNews Latest, AllPost News, Business in the News, Employer News, TeaTalkMagazine and Need to See IT.

Members are invited to review this report and seek clarification on any of the salient points.

Professor Oliver Shanley OBE
Interim Chief Executive Officer

# Committee Updates

## Quality & Safety Committee

Incorporating:
Complaints Annual Report
Mortality Surveillance (Annual) Report
Infection and Prevention Control (Annual) Report

## Audit & Risk Committee

Incorporating:
Caldicott Guardian & SIRO Annual Report

## Pension Trustees

# Committee Escalation Report to the Board of Directors

**Name of Committee:** Quality and Safety Committee (QSC)

**Date of Meeting**: 14 June 2022

**Chair of Meeting:** Professor David Sallah

## Significant Risks/Issues for Escalation:

- CAMHS Quality Improvement Plan and review of Risk Profile. Risk profile of the division under review in order to establish what the real issues and risks are, the plans in place to improve the issues and any learnings to be had.
- The importance of the correct Clinical Model for each division and that take into account patient needs and outcomes, are co-produced with patients and supported by available evidence and best practice.

## Key issues/matters discussed:

- **CQC – Restraint, segregation and seclusion review report**

  The committee were provided with the CQC's Out of Sight Report, describing the progress made on the recommendations made in the 2020 Out of Sight Report that looked at the use of restraint, seclusion and segregation in care services. The Committee had the opportunity to consider the findings and how they may impact the Charity.

- **Physical Healthcare update - Birmingham**

  The committee were provided with an update on Physical Healthcare, providing information on key areas for alert and assurance, along with a focus on the PH provision within Birmingham. The committee were informed of the impending funding cessation by NHSE for Dentistry and how that may impact the Charity.

  The Committee commented on how detailed the reports were and the assurance that they provided.

- **Delayed Transfers of Care**

  The committee were provided with an update on Delayed Transfers of Care, detailing the number of patients currently impacted, the on-going work with Provider Collaboratives and Commissioners, and the impact on LD and ASD services. It was acknowledged that this is a national problem, of which the commissioners are aware, but that it was emphasised more within the Charity due to the larger proportion of patients within the LD and ASD service than other providers.

- **Ward Clinical Models**

  The committee were provided with an update on Ward Clinical Models, highlighting the importance of divisions having differing models and the important principles to be taking into account when designing them. All the models are based on patient needs and outcomes, are co-produced with patients and supported by available evidence and best practice.

  It was agreed that feedback from staff and patients in relation to the new models would be gathered and feedback to the committee at a future meeting.

- **Medium Secure Division deep dive**

  The deep dive was presented by the division and noted. The division's presentation focussed on the key areas for assurance as requested by the Committee, including improvements post-CQC inspection; staff and patient engagement; staff retention and wellbeing; the reduction in restrictive practices; other areas of good practice; key areas of concern and the action plans in place. More detailed discussions covered the areas highlighted within the division's SWOT analysis, including staff vacancies, use of locums and staff morale and the division was requested to focus the follow-up update due at the next meeting on these areas.

- **Executive Medical Director report**

  The committee noted the EMD report that included updates on Covid and the easing of restrictions; the CAMHS service; the Patient Safety Network, progress on introducing technology to assist clinicians and current CQC activity. The Committee recognised The EMD's involvement in the Patient Safety Network and acknowledged that this will strengthen the Charity's approach to patient safety.

- **Chief Nurse report**

  The committee noted the Chief Nurse report, which included further updates on the development of Professional Nurse Advocacy, Safer Staffing and the centralised AHP function, along with information on the Allocate implementation and the work being undertaken within the Charity on Closed Cultures, including focussed training for staff and patients tailored following the interactive feedback sessions held in this area.

- **Quality Improvement Plan and Women's Service CQC progress**

  The quality Improvement plan and progress update on the CQC related actions for the Women's and Men's services were presented together and noted, highlighting much progress with implementing, embedding and closing the required actions.

  The committee discussed the improvements in this area, with the controls in place and that the QIP is now working effectively and that is essential that we keep this practice going.

- **CAMHS Quality Improvement**

  The Committee received a detailed update on the specific quality Improvement plan in place within the CAMHS service, focussing on staff shortages, safeguarding and culture.

  The committee also discussed the risk profile of the division and how that was being managed, reviewed and any issues addressed.

  The committee requested an update on the risk profile ahead of a further detailed discussion at the next meeting in order to establish what the real issues and risks are, the plans in place to improve the issues and any learnings to be had.

- **Serious Incidents**

  The serious incidents in the last period were reviewed, noting the continued improved position of investigations and reports and that commissioners have commented on the robust nature of the reports and that they demonstrate that improvements are being made following them.

- **Integrated Performance Report**

  The Integrated Performance Report was received that highlighted the quality performance indicators and progress made over the last 2 quarters as indicated within the reported metrics. Discussions were had on increasing the use of "leading" indicators that would provide some quantitative information to the Board with regards to events.

- **Covid-19 update**

  The committee received a verbal update highlighting the removal of Covid related restrictions, and the slight increase in infections, most likely seen due to the recent Jubilee celebrations.

  The committee received assurances that the Charity had established and robust mechanisms in place for Covid, that could be reintroduced very easily and that the Charity has a strong pipeline of PPE with sufficient stock levels.

- **Quality and Safety Group (QSG)**

  The Quality and Safety Group report was received and noted, highlighting the discussions had at both the Safety and Experience element and the Compliance and Effectiveness element of the meeting and that they covered all the areas brought to the committee.

- **Mental Health Law Steering Group (MHLSG)**

  The Mental Health Law Steering Group report was received and noted. The importance of the committee receiving this update was re-iterated, confirming that this was the required route for the Board to receive assurance on MHA topics. It was agreed that in future the MHLSG would introduce metrics within its update to aid the assurance process.

## Decisions made by the Committee:

- **PALS & Complaints Annual Report -** the Committee approved the report for submission to the Board
- **Mortality Surveillance Report -** the Committee approved the Annual Mortality report for submission to the Board
- **Infection Prevention & Control Annual Report -** the Committee approved the report for submission to the Board
- **Covid-19 update –** the Committee agreed that they no longer required an update on Covid-19 at each meeting. Any updates in future will be provided via either the EMD or Chief Nurse reports as appropriate.

## Implications for the Charity Risk Register or Board Assurance Framework:

- Detailed review of the CAMHS service risk profile is underway and will result in changes to the material and operational risk registers. These will be reviewed in detail at the August QSC.

## Issues/Items for referral to other Committees:

- None

## Issues Escalated to the Board of Directors for Decision:

- Annual Pals & Complaints Annual Report
- Annual Mortality (Learning from deaths) Report
- Infection Prevention & Control Annual Report

## Appendices:

- 2021-22 Annual PALS & Complaints Report
- Annual Mortality Report (2021-2022)
- 2021-22 IPC Annual Report

## St Andrew's Healthcare

# Learning from Feedback

## Annual PALS & Complaints Report

## 2021/2022

## Contents

## 1. Introduction

This report summarises PALS (patient advice and liaison service) and Complaints activity and performance at St Andrew's Healthcare for the year 1st April 2021 to 31st March 2022. We recognise that our patients, service users, families, carers and external professionals have a range of experiences of working with us and using our services. Their feedback provides the Charity with a vital source of insight about where good practice is evident, as well as where our standards fall short, and it is essential we learn from this to improve our services and the experiences of those who use them.

As a Charity, we provide mechanisms for people to provide both positive and negative experiences and we encourage an open culture that welcomes such feedback so we may continually improve. Where possible, colleagues take immediate action to put things right at the first point of contact. Where this is not possible, we provide a robust complaints process. This is supported by the PALS and Complaints Team, whose core aims are to:

- Provide impartial support for patients, service users, families, carers and St Andrew's Healthcare staff
- Provide advice and guidance throughout the complaints process
- Identify Advocacy needs
- Facilitate informal mediation
- Ensure appropriate allocation of investigations to provide thorough, accurate and high quality complaint investigations
- Identify complaint trends or other causes of concern and escalate as necessary
- Identify compliment trends to highlight areas of good practice
- Ensure provision of high quality training on complaint handling to staff
- Provide accurate and up to date performance information about complaints, concerns, comments and compliments to help inform service improvements
- Generate accurate and up to date performance information for managers to help them to monitor complaints, concerns and comments in their specific area, identifying any potential 'hotspots' and enabling learning and staff performance management

The Chief Executive Officer is accountable for ensuring the efficient operation of the complaints policy and associated procedures, and is responsible for approving and signing complaint response letters.

The PALS, Complaints and Patient Engagement Manager oversees the daily operation of complaints handling and gives priority and importance to good complaint handling to set the tone and act as an example for all staff.

The Divisions and other services are responsible for adopting a fair and consistent approach to the investigation of all complaints and concerns. They are accountable for extracting learning from complaints to continually improve the quality of service provided and involve the person who raised the complaint in the action plan for learning and change as far as is possible.

During the period 1st April 2021 to 31st March 2022 we received 218 complaints; of which 25 were dealt with as Safeguarding (SG) and investigated under our Safeguarding Policy, and 193 investigated under our Complaints procedure. We responded to a further 198 concerns and we received 370 compliments, 23 comments, 32 enquiries and 1 suggestion.

Staff are encouraged to try to resolve concerns at ward or divisional level in the first instance. Where this is not possible, they can direct people to the PALS and Complaints

Team. A dedicated email address and telephone number is available and patient telephones have a direct line to the team using hotkey 2.

The PALS and Complaints Team assesses the level of complexity of each complaint and where possible, discusses which level of complaint and process they feel it falls into with the person raising the complaint. If the complexity and / or severity of the complaint is assessed to sit in level 1 or 2, local resolution will be recommended and encouraged. Our Local Resolution guidance and forms help simplify the process and ensure the patient is involved in the resolution and, where possible and appropriate, the changes. Emphasis is put on the level of satisfaction after resolution. Complaints that are deemed to fall into level 3 are investigated formally. A complaint investigation report template and guidance is provided, again emphasising the importance of the learning and involvement of the person raising the complaint. During the period, response letters were introduced acknowledging receipt of a signed local resolution form. This was created in response to a patient whose complaint had been addressed via local resolution, but they could not remember this and were expecting a letter in response to formally close the complaint record. In situations where attempts at local resolution are unsuccessful, but there is no justification for an investigation, the letter will acknowledge and apologise that they remain dissatisfied and will confirm that as there is nothing further to investigate and so the complaint record will be closed.

Regrettably, vacancies and long-term sickness within the team caused an inability to provide drop-ins across any of our sites, which will have had an impact on raising complaints and concerns for some patients who prefer to discuss this face to face. We had intended to be early adopters of the new NHS Complaint Standards in 2021/22. Gaining stakeholder feedback to assess current processes against the Standards was challenging, with only patients and PALS & Complaints Team staff providing feedback. A PHSO webinar in September 2021 showed that lack of engagement in assessing the baseline against the Standards was not unique to St Andrew's.

**2. Definitions**

**Complaint:** A Complaint is an allegation that something has gone fundamentally wrong and where set procedures have not been followed resulting in a person expressing their dissatisfaction.

**Concern:** A Concern is an expression of opinion that something is or has gone wrong. It is something, according to the person's perception, that has let them down in regards to what they expected to happen.

**Compliment:** A compliment is any spontaneous expression of satisfaction or praise that is above and beyond gratitude shown as a general courtesy. A compliment will be regarding the quality of service provided to patients, relatives, carers, or members of the public or their representatives.

These definitions will be further clarified as part of the review of policy and procedure to bring our practices fully in line with the new NHS Complaint Standards. At present, the definitions do not helpfully distinguish between concerns and complaints.

We record and respond to all complaints and concerns irrespective of how they are presented. The PALS and Complaints Team have continued to strive to speak with all persons who raise their concern in writing, by letter or email, upon receipt, to acknowledge this and to ensure that their concerns or complaint are fully understood and the team

understands how the person would like the issue resolved. This conversation also ensures the person understands the process and any support needs are identified; timescales are discussed and agreed and their preferred method of communication confirmed. This also provides an opportunity to resolve any concerns immediately if this is possible.

Concerns and complaints are managed in the following ways:

**Concerns:**
Concerns that cannot be dealt with immediately within the service are usually managed through the PALS part of the PALS and Complaints Team. These are usually queries or expressions of frustration; requests for information that do not require detailed investigation but may require guidance, signposting, or information. These issues are recorded and dealt with in real time by our PALS and Complaints Team or by a relevant member of staff, who is able to offer appropriate information. If the matter is not resolved to the person's satisfaction, then the concern may be escalated to a formal complaint. If someone raises a complaint, which is low level in terms of complexity and severity, we will strive to discuss with them the option of resolving this as a concern which can reduce the time they are waiting for a resolution as opposed to the formal complaint process. Once people understand this does not mean their concern is given any less attention or taken any less seriously, many are happy to proceed in this way.

**Complaints:**
The Charity investigates complaints in a manner appropriate to the issues raised and where appropriate we seek and obtain consent for an independent review. We aim to resolve all complaints promptly and efficiently, keeping the person who raised the complaint fully informed as far as is reasonably practicable, as to the progress of the investigation and any delays. We have maintained regular contact in a number of cases where a response to the person's complaint has been delayed and this has helped to alleviate feelings that they are being ignored or not taken seriously and provides reassurance that progress is being made.

One carer told us "Many thanks for this. Much appreciated our phone call originally, [it] was very heart-warming, you nailed the essence and emotion I was trying to convey."

One patient told us they felt listened to due to having an acknowledgement of their complaint in writing, and also the subsequent conversation with staff.

The PALS, Complaints and Patient Engagement Manager and PALS & Complaints Officers triage each complaint. This ensures a consistent approach and an independent view of the issues raised and actions to be taken. The triage is carried out in line with the complaint levels outlined in the complaints procedure. All complaints are acknowledged formally within 3 working days of receipt. This is normally done in writing and a member of the PALS and Complaints Team will either send an acknowledgement by post or request a staff member on the ward to give this to the patient. A timeframe is identified and, if appropriate, negotiated with the person raising the complaint at the start of investigation. This is intended to ensure a realistic timescale is given in the context of the anticipated investigation. The Charity aims to resolve complaints within 30 working days. For complex cases, this may be longer if investigation, external review, or Root Cause Analysis is required. The focus is to provide a quality, thorough, open candid investigation and response, which sometimes may necessitate a longer period.

## 3. Activity and Performance

This section provides an overview and breakdown of key performance and activity data for 2021/22. It includes the number of complaints and concerns received; the number of

complaints closed; response times; a breakdown of the themes most frequently raised in complaints and other PALS activity. Plans for further improving performance for 2022/23 are detailed in section 5 of this report.

Table 1 – Overview of PALS & Complaints activity by year

| | 2019/20 | 2020/21 | 2021/22 |
|---|---|---|---|
| Number of complaints received (inc. SGs) | 245 | 224 | 218 |
| Number of complaints investigated as Safeguarding (SG) | 21 | 29 | 25 |
| Number of complaints closed* | 222 | 210 | 231 |
| Number of concerns received | 176 | 113 | 198 |
| Number of compliments received | 346 | 468 | 370 |
| Number of comments, enquiries & suggestions | N/A | N/A | 56 |
| **Total number of PALS & Complaints records logged** | **788**** | **834**** | **842** |
| Complaints referred to the PHSO | 5 | 4 | 9 |

*includes complaints receieved towards end of previous financial year
**excludes comments, enquiries & suggestions

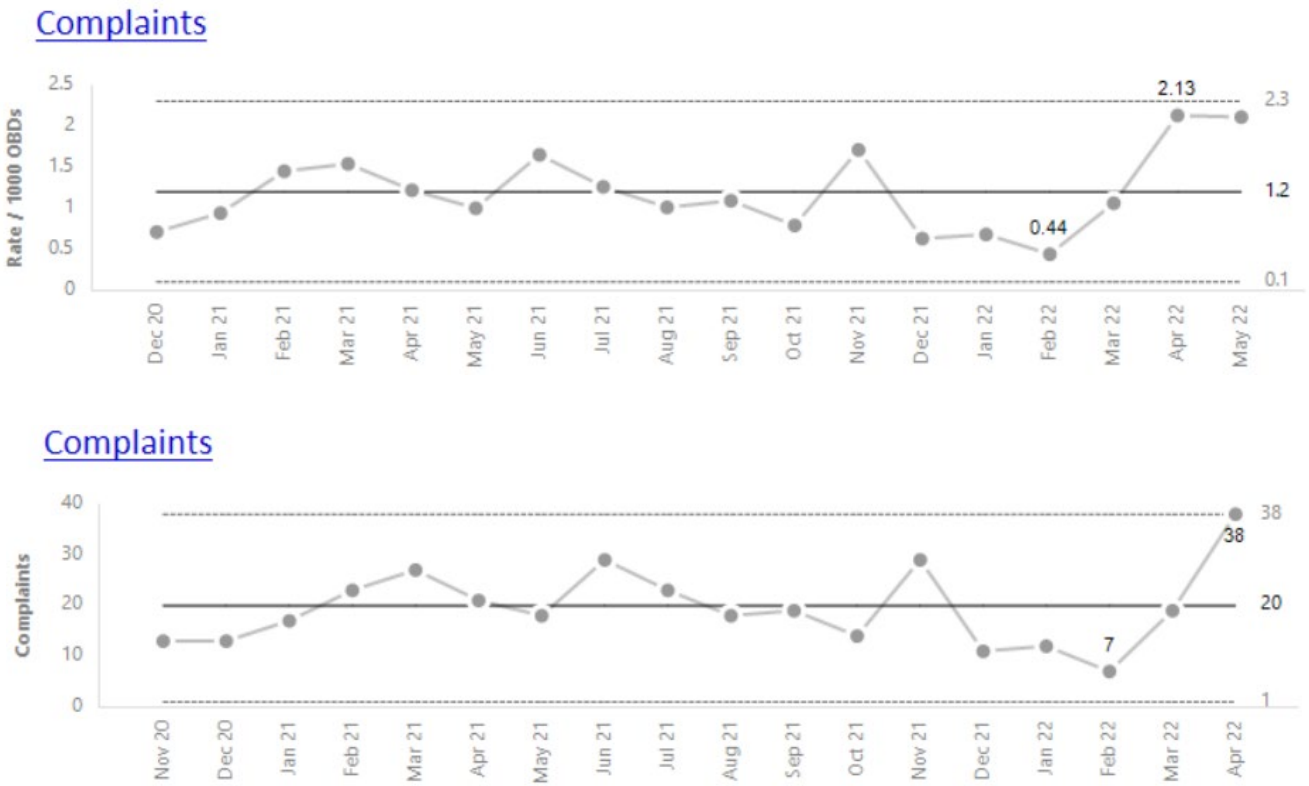
Table 1 shows the number of complaints received remains relatively stable year on year, but does not indicate level of complexity, which anecdotally has increased year on year. Counterparts in healthcare organisations across the UK also identified a significant increase in the complexity of complaints being raised during discussion at the National Complaints Forum in May 2021.

A significant number of concerns raised relate in the main to concerns about our implementation of COVID-19 guidance. As an inpatient healthcare provider, we had to implement guidance that differed significantly from the guidance provided to the general public.

Parliamentary and Health Service Ombudsman:
The number of complaints known to be referred to the PHSO in 2021/22 was 9 and of these, 5 were not considered to have been properly made, 1 was withdrawn, and 1 was out of remit. We have been informed that two are at early consideration stage, with no time frame given for when they will have finished their considerations.

3.1 Complaints and concerns received

Table 2: Number of complaints by 100 occupied bed days and by count




Source: Safety dashboard

Table 2 demonstrates the monthly fluctuations in complaints received. The number of complaints received from December to March shows an extension of the usual “winter lull” in complaints received. It should be acknowledged that conversely, the number of concerns raised in that period (January – March) increased. This could be attributed to the addition of newly recruited PALS & Complaints Officers who have been able to assist in resolving issues at an earlier stage, preventing the escalation of these issues to complaints.

Table 3: Number of complaints compared with number of complaints investiagted as Safeguarding (SG) by Division for 2021/22

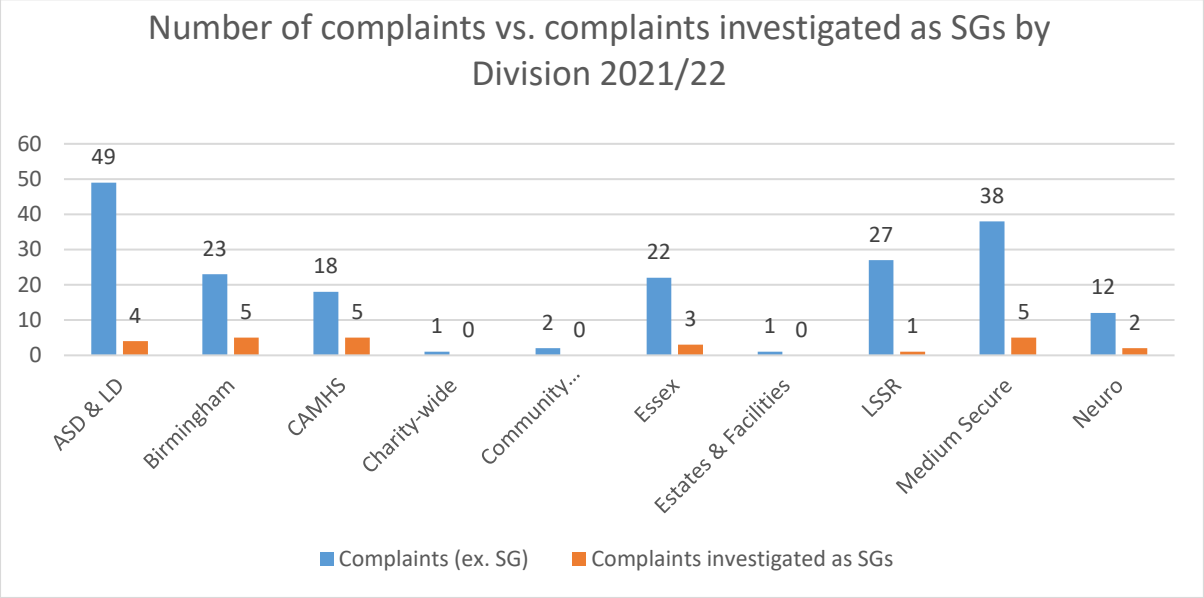
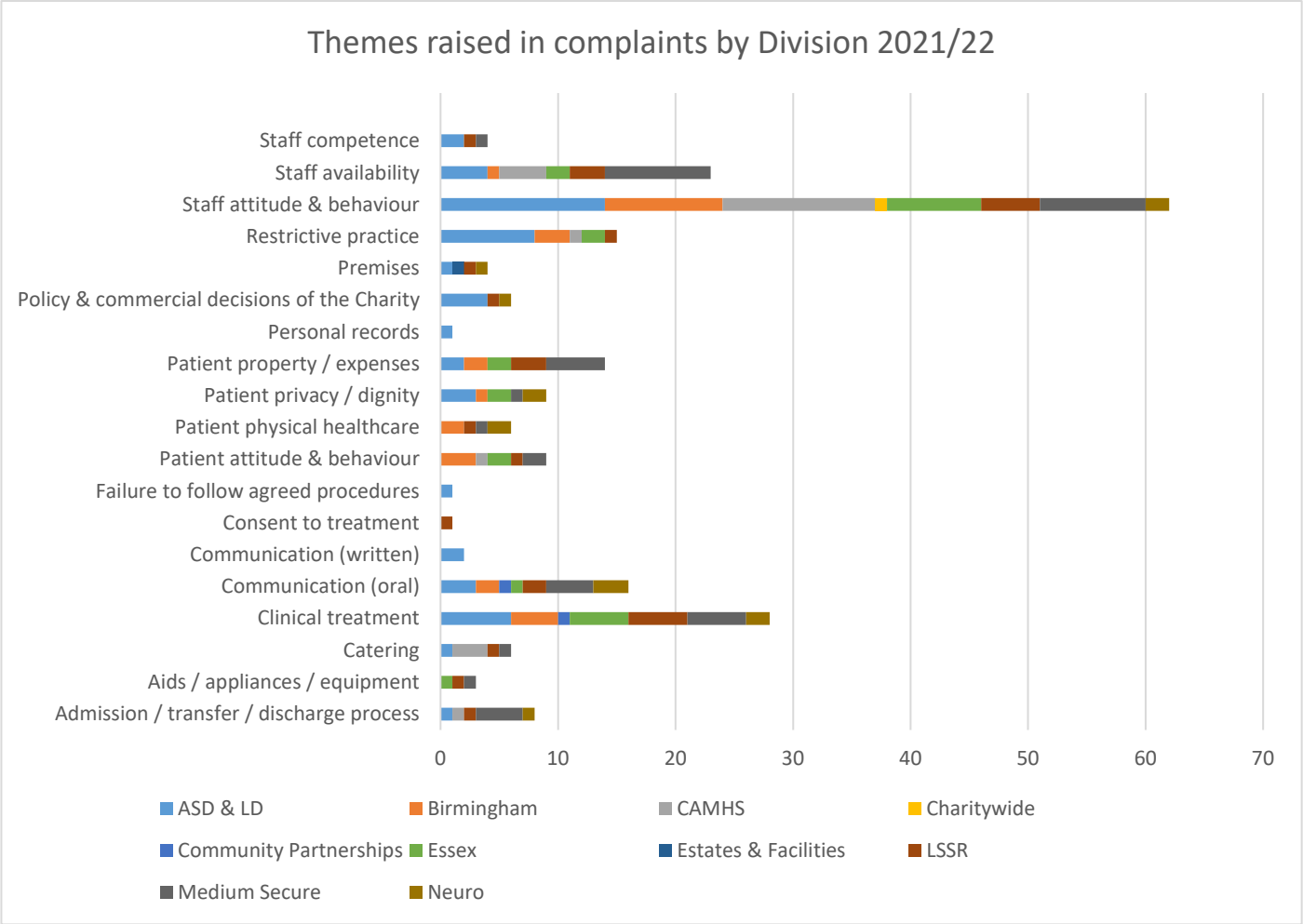



Table 3 shows that the distribution of complaints investigated through the Safeguarding process was more evenly spread across the Divisions than in the previous year. However, CAMHS remains the Division with the highest proportion of complaints investigated through the Safeguarding process at 22% of all complaints received throughout the year.

Due to the varying numbers of patients per division, it is difficult to make direct comparisons in terms of figures and our current reporting does not allow us to track complaints per 1000 occupied bed day by division over a year.

### 3.2 Themes in complaints

Table 4: Themes raised in complaints by Division 2021/22




The category s*taff attitude and behaviour* is the most common theme raised in complaints, with the theme comprising 28% of all complaints raised. For the year 2021/22, complaints about staff attitude and behaviour include everything from members of staff allegedly being rude to patients or carers, to them being too aggressive in carrying out physical interventions. themes, so that trends can be identified. Changes to the DATIX form on which complaints are recorded will provide greater detail on what exactly the issue is within each complaint theme. When investigating a complaint that has been categorised as *staff attitude and behaviour*, staff are guided to consider:

- Do any complaints pertain to particular members of staff more than twice?
- Is it related to a specific career level of staff?
- Are staff who are the subject of a complaint informed / how are they informed?
- Is this reviewed in supervisions?
- What are the opportunities to update relevant training?
- Are staff members who are subject to a complaint receiving appropriate pastoral support?

*Clinical treatment* is the next most common theme of complaints, followed by s*taff availability*. *Clinical treatment* relates to disagreements about medication or specific elements of care

plans in the main, and complaints about *staff availability* have generally been either in relation to patients not feeling safe on the ward, or not feeling enough activity is being offered on or off the ward due to staffing levels.

The complaints about *policy and commercial decisions of the Charity* relate in the main to patients and their families feeling our implementation of COVID-19 guidance was unfair. UKHSA followed up one family's complaint about our ward outbreak and isolation procedures and confirmed they were satisfied with our approach. The other complaints about our policies are in relation to being a smoke-free site.

There were three group complaints in relation to catering following a trial of freeze-cook meals that were piloted on select wards. The patient feedback on these contributed to the decision not to pursue this option for patient meals.

A group complaint was made by all patients on one LSSR ward who were dissatisfied with their level of access to Gloucester House gym and swimming pool. In relation to the complaint, the Charity committed to training additional staff members as lifeguards.

Following concerns about the high volume of complaints from one of the CAMHS wards, the PALS, Complaints & Patient Engagement Manager met with the Divisional Head of Operations and Head of Nursing to discuss concerns. They confirmed that the acuity level on the ward, in addition to an open culture of welcoming complaints, was playing a part in the rise of complaints. Furthermore, there was a very inexperienced staff group for whom relational security was not at the necessary standard to be effective. Therefore, the Division purchased a package of relational security training for all their staff in an effort to address this training need.

Following numerous concerns from patients and carers of a particular LSSR ward regarding inconsistencies in delivery of care and what appeared to be a punitive approach to risk management, one of the Healthcare Case Investigators undertook a deep dive investigation into the ward. The investigation highlighted issues with the physical environment, a lack of unified leadership and inexperienced staff. The ward was later closed and patients relocated to different St Andrew's wards or other providers.

Table 5: Number of Concerns, Compliments, Comments, Enquiries and Suggestions April 21 - March 22

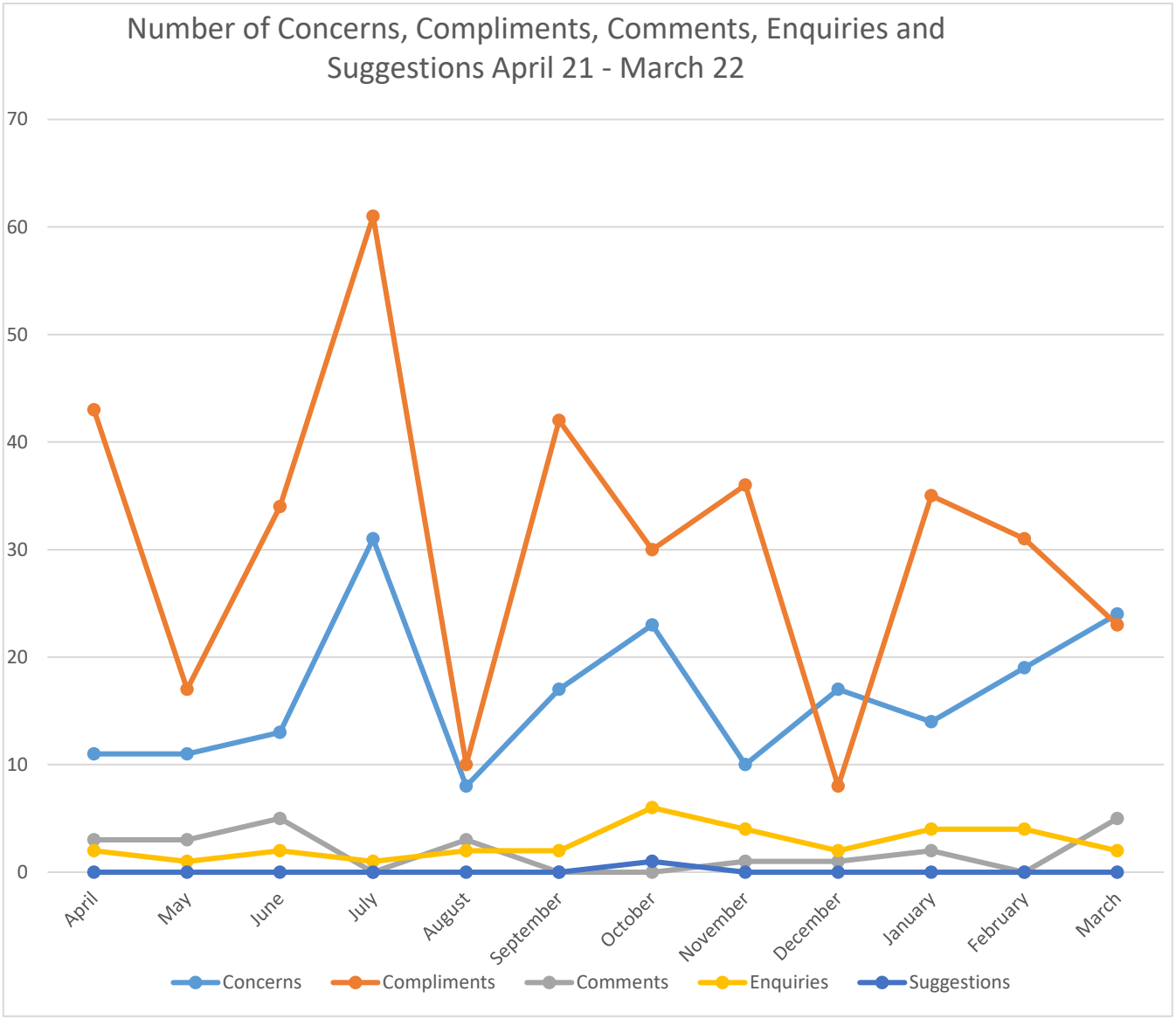



Table 5 demonstrates significant fluctuations in the recording of compliments during the course of the year, which was a result of resourcing constraints at times leading to the prioritisation of addressing complaints and concerns rather than logging compliments. From January – March 2022, there is an increase in the number of concerns received, which could be attributed to the increased resource within the team enabling issues to be dealt with more quickly, avoiding the need for escalation to complaint stage.

3.3 Complaints by method

Written complaints comprise the majroty of those receieved by the team, whether via ward feedback forms or scans of handwritten patient letters that are then emailed by ward staff. Telephone is the second most popular method of contact used, with an increase in use seen since welcoming new PALS & Complaints Officers to the team. The third most popular method of contact is email, which tends to be favoured by carers. 22% of all complaints were receieved via the CQC, with many of these already being known to the PALS & Complaints Team. Changes to the PALS & Complaints Datix record will enable further analysis in the

future regarding how a complaint is raised (via Advocate, solicitor, MP or CQC) and whether it was raised by a patient, carer or external professional.

3.4 Compliments

The Charity records the number of compliments received*. These are monitored by the PALS and Complaints Team via a dedicated compliments e-mail address. A variety of methods are used to capture compliments, namely; Friends and Family Test, letters/cards, Care Opinion, e-mail and face to face. Compliments are mainly received from carers and patients, though external professionals do also provide positive feedback. 36% of compliments were made by families and carers, 33% were made by patients and 31% were made by external professionals.

A log of compliments received is sent to the Communications Team monthly. They then highlight these across social media platforms and internal and external communications. There were 373 compliments received in 2021/22 and 11 stories were shared on Care Opinion.

Table 6: Compliments raised by Division 2021/22

| | ASD & LD | Birmingham | CAMHS | Enabling functions | Community partnerships | Essex | LSSR | Med Sec | Neuro |
|---|---|---|---|---|---|---|---|---|---|
| No. compliments | 75 | 8 | 27 | 25 | 50 | 38 | 57 | 25 | 68 |
| % of Charity total compliments | 20 | 2 | 8 | 7 | 13 | 10 | 15 | 7 | 18 |

Table 6 indicates that it might be helpful for the PALS & Complaints Team to create an awareness campaign about how and why compliments are recorded, so that each Division maximises opportunities to acknowledge and share their good practice.

Table 7: Number of compliments by theme 2021/22

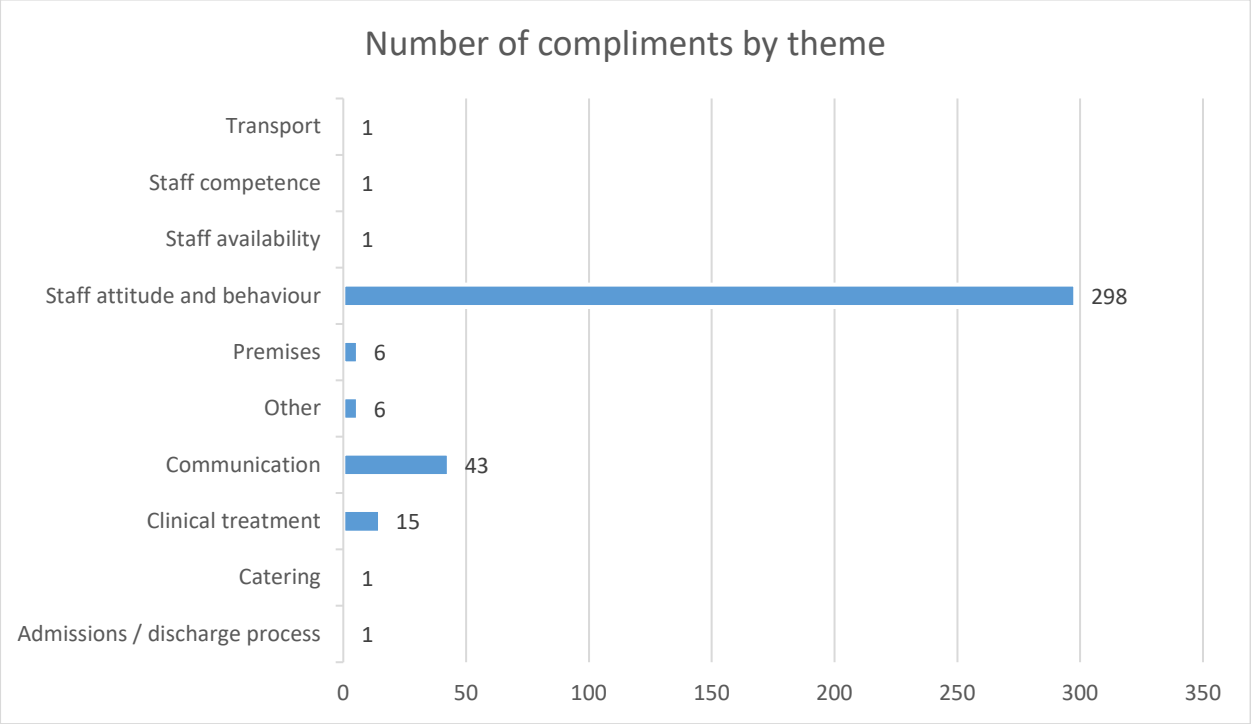



Table 7 shows that the most significant theme across compliments logged was staff attitude and behaviour. These compliments align closely to our CARE values of compassion, accountability, respect and excellence. For all compliments logged, the subject/team and any relevant line managers are made aware that they have been the recipient of a compliment.

* Compliments from St Andrew's staff about St Andrew's staff are not recorded via this mechanism. They are referred to the CARE Awards.

3.5 Examples of compliments received

From the family member of a medium secure patient

- I wouldn't have a son if it wasn't for St Andrew's, what they do for him and how they care for him. St Andrew's have done such hard work to keep him alive and have fought for him all the way. I could never have done what he has done on my own, all the legal things I can't thank them enough too. Without that we wouldn't have him. My son wants to live because of St Andrew's. I really, really appreciate everything that they have done I could never have done that on my own. They went over and above when he was ill the Doctor even stayed over in hospital. They have helped him to see there is more to life, they even make sure he has an interpreter at every single hospital appointment. I know it's been a whole team effort and I have complete trust in Dr H and the team.

From the family member of an ASD patient

- C has just phoned me to say you are the best Consultant he has ever had - and he has had a few! Thank you for your supportive, caring and non-judgemental approach - it means a lot. I thought I would send you a picture of C seven years ago so you can see what his illness has done to him. However, I am confident you will help him recover.

From a Provider Collaborative Quality and Governance Lead following a visit to an LD ward

- I wanted to email to express my gratitude and praise for the team working that day. I was made to feel welcome on the ward, and despite the team clearly being very busy with their day jobs, they did everything to accommodate me and provide me with the information that I needed. Where any information could not be sought on the day, the team have been responsive since in supplying me with this via email. I want to give particular praise to the nurse in charge on that day, he was an absolute pleasure to be around. His calm, approachable and friendly nature was clearly visible, not only to myself, but in the interactions I witnessed with patients too. He demonstrated sound knowledge of the patients and a compassionate approach – truly an asset to your service.

From an Essex patient

- Since being on Audley Ward, L has shown me so much respect. Nothing is ever too much for him. L finds himself time to play scrabble with me daily and he even lets me win! I know that when I first arrived at hospital I was extremely unwell. But with L's support and encouragement I feel a million times better. I'm hopeful of being discharged back home soon but I will always remember L, he is a legend!

## 4. Closed complaints

This section provides information relating to complaints closed during 2021/22 using the categories reported. Throughout the year, the Charity aimed to provide a response to complaints within 30 working days.

Of the 193 complaints (excluding complaints investigated through Safeguarding) opened during 2021/22, 185 were closed as of 1st April 2022. Of the 18 active complaints remaining, 13 were still within the 30 working day timeframe. The 5 overdue complaints were caused by the complexity of the cases (x 3) and the other 2 were due to delays in the Divisions providing necessary information. In all cases when a complaint is likely to become overdue, the complainant is contacted to inform them of the situation, apologise for the delay and be informed of the expected new timeframe.

### 4.1 Response times

In 2021/22 the Charity committed to providing a response to all complaints within 30 working days. Our achievement of providing responses within this agreed timescale was 43%, which is over half the 78% achievement of the previous year. 23 complaints had extensions agreed when it became apparent that they would not be resolved within 30 working days, either due to the complainant adding additional concerns, or due to delays in receiving the necessary information from the service. The failure to achieve the 95% target for the year can be attributed to several contributory factors including resource constraints within the PALS &

Complaints Team due to vacancies and long term sickness absence, patients' declining mental health postponing successful resolution of issues and failure to receive the necessary information from the Divisions. The movement of ward staff across the organisation has not always been reflected in the key contacts lists for wards, delaying the establishment of responsibility to address complaints and lack of ownership in addressing complaints and concerns through to completion as staff move.

We had planned to adopt a more tailored approach to providing timescales for complaint resolution, in line with the new NHS Complaint Standards. However, vacancies and long-term sickness absence within the team resulted in a delay in fully implementing this approach. The weekly updates to Divisions ceased in January due to the need to focus efforts on the induction and training of new staff. In 2022/23 we aim to create an accessible dashboard that will enable Divisions to have greater oversight of their active complaints and outstanding actions and will be reviewing our timeframes in line with the NHS Complaint Standards (see Section 7: Priorities for 2022/23).

4.2 Extensions
Extensions to response deadlines were granted across 2021/22. Of the 105 complaints that were not responded to within the 30 working day timescale, 23 of these had been granted extensions. In every case, the person who raised the complaint was kept updated about delays.

4.3 Outcomes of complaint investigations
For all concerns and complaints raised, we believe there is useful learning to be identified that will help improve our services. Through the development of strong working relationships with colleagues across all sites, the focus of investigations continues to be identifying where improvements to systems, processes and staff knowledge or performance could enhance the patient or carer experience and prevent reoccurrences of issues. Staff are encouraged not to fear complaints, and rather to view them as invaluable pieces of information that enable us to improve. Seeking feedback from people who have raised a complaint provides valuable insight into the user experience of the complaint process so we can improve where necessary to increase the satisfaction of those who make complaints.

Throughout the period there was a disappointing lack of learning identified from complaints at a local level, with some identified learning highlighting practices that should be followed as standard, such as patient inclusion in the creation of their care plans and accurate recording of patient property. The repetition of such common complaints is further evidence that some of the learning identified in the complaints process is not resulting in actions that improve patient experience. Whilst not all complaints raised allow for a specific change, there are key learnings that could help prevent an issue from recurring and have a broader impact on service and quality improvements.

There is currently no mechanism in place to monitor the learning and any action / change from a complaint. A Charity-wide project, led by one of the Heads of Nursing, is looking to embed learning from complaints, CQC enquiries, Serious Incidents and Safeguarding across the organisation and to ensure accountability for identifying lessons and implementing change sits within Divisions and ward teams. Lessons learned are captured on DATIX and included in the monthly reports that Divisions receive. The Quality Team's Quality Business Partners have oversight of all complaints reports and provide a degree of monitoring and support to the Divisions to create and implement action plans based on lessons learned. Lessons learned are reported to the Quality and Safety Group and Court of Governors. Where a potential CQI (continuous quality improvement) project has been identified via the complaints process, this is highlighted to the Divisions in monthly reports.

Table 8: Examples of learning and actions from complaints by complaint theme

| |
|---|
| **Complaint theme -** Admission / transfer / discharge process<br>**Lessons learned / improvements made -**<br>• Ensure carers understand our duties surrounding patient consent to share information and that feel supported if their loved one refuses consent.<br>• Ensure medication travels with patients when discharged or transferred.<br>• Reassure patients that they can ask any questions or share any concerns they have about the discharge process so they can be supported with any anxiety they may have about the process.<br>• Patient would like to move closer to home and family, so staff are working with commissioners and home team to identify suitable placements.<br>• Ensure thorough risk assessments are sent to potential new placements to avoid delays in transfer.<br>• Ensure single point of contact is established with new placement providers and ensure confirmation is gained on receipt and understanding of information shared. |
| **Complaint theme -** Aids / appliances / equipment<br>**Lessons learned / improvements made -**<br>• We work within NHS guidelines in operating a non-smoking site. A pilot is being carried out to provide vapes on admission. Audley Ward has volunteered for roll out.<br>• Ensure carers know that they are not expected to purchase any equipment to support a loved one's recovery. Ensure patients are supported to have regular contact with families. |
| **Complaint theme –** Catering<br>**Lessons learned / improvements made -**<br>• The kitchen has been instructed to ensure that her menu selections are followed going forward.<br>• Patient engagement prior, during and after projects is essential. |
| **Complaint theme -** Clinical treatment<br>**Lessons learned / improvements made -**<br>• Patient now has access to spare night clothes. Team have sought support to aid patient's communication difficulties due to learning disability. Encourage patient to use 1:1 sessions and approach ward staff if she feels unsafe.<br>• Continue to provide family with information about son's treatment in a way that supports the family's communication needs.<br>• Lessons from the incident when patient had a seizure will be addressed by the safeguarding investigation. Remote/online assessments of patients can make it more difficult to assess their needs prior to admission. Ideally, preadmission assessments should take place face-to-face. Ensure (where there is consent) that families are understanding of the treatment their loved one needs, to reduce any anxiety they may have about their detention in hospital.<br>• All staff members should treat patients with compassion, respect and care. Concerns about this member of staff's attitude and conduct with patients has been highlighted and will be addressed by their line manager.<br>• Ensure all medical appointments are attended on time. Ensure there is sufficient time during medical appointments to check a patient's understanding of treatment plans so they can make informed consent.<br>• Ensure sustainable level of communication is planned and maintained for carers/family members with members of MDT so queries and concerns can be addressed immediately. |

- Patient gives limited consent to family receiving updates on his care, causing them anxiety about his treatment. Continue to support family, within limits of patient's consent for them to have information.
- Pharmacy to ensure medications are accurately labelled and it is clear if medications are modified or standard release. Nursing staff to ensure they check medication deliveries and that packaging and label match.
- Ensure patients are kept informed of any delays in accessing services and the reasons for these delays.
- All clinicians need to access notes prior to the day of their appointments. Administrators need to make clinicians aware of whether a new patient has been seen in our service previously in order to ensure the new clinician is aware that there will be more reports and RiO notes that need to be reviewed prior to the appointment than there normally would be. All clinicians will be reminded that the service standard is for reports to be completed within 2 weeks of an appointment.
- Patient is struggling with motivation to carry out morning routine that would enable him to gain greater access to computer by missing planning meetings to allocate him time on the computer.
- Patient has no insight into their illness, therefore does not trust opinions of clinical professionals.
- Ligature point audit has identified additional ligature points. Door in seclusion room required maintenance. Whenever possible, try to provide same sex staff on enhanced observations to maintain dignity of patient.

**Complaint theme -** Communication (oral)
**Lessons learned / improvements made -**

- Staff to ensure they are staying aware of any technology issues when attending online meetings
- The transfer was planned with patient's safety as priority, hence the lack of notification she received.
- Communicate clearly with carers and agree time for conversations to take place if necessary staff are unavailable at the time.
- Ensure meetings are planned in enough time to check any necessary equipment or technology is working.
- Ensure there is a clear process for communication with external professionals.
- Ensure all documentation of events is filled out quickly and accurately.
- The need to rely on video and phone appointments during the pandemic has resulted in increased challenges to creating therapeutic bonds between clinicians and clients, leading to gaps in relational security risk assessments, as these issues would be more easily understood if meeting regularly in person.
- Staff must ensure that dysphagia care plans are followed thoroughly.
- Where there is patient consent, it is important to contact family members immediately about significant updates such as admission to general hospital. Significant changes in staffing and leadership can cause problems in providing consistently high standards of care for patients and communication with family members.

**Complaint theme -** Communication (written)
**Lessons learned / improvements made -**

- Review information sent to family and friends ahead of Tribunal meetings to ensure it provides necessary detail of what to expect.
- Ensure accuracy of family history in reports. Do not presume complete accuracy is present in previous reports without evidence of where the information came from.

**Complaint theme -** Consent to treatment
**Lessons learned / improvements made -**

- Ensure that COVID-19 isolation and quarantine rules are explained clearly to patients and they understand the reasons for these.

**Complaint theme -** Failure to follow agreed procedures
**Lessons learned / improvements made -**

- Ensure patient fully understands their care plan regarding diabetic blood sugar management and its impact on access to leave, and ensure all staff follow the agreed plan.

**Complaint theme -** Patient attitude & behaviour
**Lessons learned / improvements made -**

- Ensure patients are aware of social expectations regarding language and noise levels when on community leave.
- Patient would like to see consistency in MDT decision making, but this needs to be balanced with protecting individuals' right to confidentiality and acknowledging that all patients are individually risk assessed, therefore sometimes patients appear to be being treated differently, but staff are unable to share the specific reasons for this.
- Patient is not appropriately placed to suit their sensory needs. New placements being pursued.

**Complaint theme -** Patient physical healthcare
**Lessons learned / improvements made -**

- Patient's new care plan has been devised and patient is being informed of any changes. Patients to be made aware their family can be included in producing care plans if they wish.
- Patient's friend is not next of kin and so has no sway in her discharge. Safeguarding investigations showed no further need for action.

**Complaint theme -** Patient privacy / dignity
**Lessons learned / improvements made -**

- Ensure clear communication with patients about actions taken to meet their requests in ward round.
- Ensure body maps are completed following physical interventions to include observations for continence and well being.
- Staff have been reminded about importance of keeping confidential information out of view in nursing office.
- Ward teams to provide reassurance to transgender patients that their choices are respected.
- Staff to revisit equality and diversity and staff to attend unconscious bias training
- Nurse Manager discussed all of patient's complaints with him and explained rationale behind some of the issues - e.g. MOJ restrictions not allowing leave for a haircut. Also explained the finance process in St Andrew's, the clinical rationale behind treatment offered is based on current presentation and confirmed to patient that the ward phone has not been cloned. Patient expressed they were happy with the information received.
- Patient to be encouraged to take care of their oral hygiene.
- Staff have been reminded to support patient to dress in a way he would be happy with.

**Complaint theme -** Patient property / expenses
**Lessons learned / improvements made -**

- Ensure all patient property records are accurate and property is stored securely.
- Lesson for PALS & Complaints: consider patients' mental state when resolving complaints and put more structured measures in place to close complaints when resolved, but patient too unwell to sign to acknowledge.
- The allowance for our Prison and Remand Patients are in line with NHS guidelines
- Staff will check balance before giving him money at each stage. Sometimes SU makes orders for e-cigs, and the amount is credited to his account at a later date, staff will keep track of his purchases to avoid over spending. Care co-ordinator to support CB with budgeting skills as part of his support plan
- Document contact with family and carers to ensure that any follow up queries can be accurately addressed.
- Staff would benefit from guidance about post death processes
- Ensure patient property is recorded and stored securely and property lists are updated regularly to provide accurate information. Establish a sustainable level of family/carer communication so families have opportunity to ask questions or raise concerns.
- When carrying out patient finance tasks, ensure accuracy of information put into system.

**Complaint theme -** Policy & commercial decisions of the Charity
**Lessons learned / improvements made -**

- Ensure patients and their families understand the rules and procedures within St Andrew's.
- All measures in relation to COVID-19 ward isolation were correctly followed and communicated.

**Complaint theme -** Premises
**Lessons learned / improvements made -**

- Ensure all estates and facilities tasks are addressed in a timely manner
- Patient had been supported to raise complaint via ward staff and advocacy.
- Ensure sufficient staff numbers are qualified as lifeguards so patients may access swimming sessions.

**Complaint theme -** Restrictive practice
**Lessons learned / improvements made -**

- Ensure meeting minutes accurately reflect decisions and conversations had in meetings.
- Ensure communication with carers is clear regarding purpose of constant obs during visits
- Continue to support patient through regular review of care plans.
- Staff to return items removed from rooms immediately if they are deemed safe to have. Encourage patients to discuss concerns before and after interventions such as room searches.
- Provide a timetable for patients to plan their time around. Support patient's communication needs by providing written documentation of decisions made at ward round, including rationale.
- Part of patient's mental health problems are persistent feelings of persecution and paranoia that others are trying to sabotage his life. Consistent reinforcement of boundaries and clear communication are needed.

**Complaint theme -** Staff attitude & behaviour
**Lessons learned / improvements made -**

- Follow up conversation to ensure that mother understood the circumstances of the restraint would have been beneficial.
- We have learned from this as although the sharing of information to the ward MDT via an email is normal practice, the report could have been circulated to just the Nurse Manager and RC, then brought to a meeting for discussion and then uploaded to Rio. The ward team have been made aware that they are to be clear with patients about who has professional privilege to access their information and to let them know that sharing only relates to your care risk management and how this is shared with the wider team.
- New relational security training has been purchased to try to prevent such situations occurring.
- Work with patients to support them in managing their finances through care plans. Ensure these are adjusted/updated regularly to adapt to a patient's possible changing needs in this area.
- Increased training has been delivered to staff in relation to patients with eating disorder. Doctor with extensive inpatient eating disorder experience will now be RC and/or liaise with other RCs when patients are admitted who have an eating disorder.
- No wrongdoing by staff member. However, staff to be aware that masks present a safety risk with some patients who may try to use the metal nose part to self harm
- In order to safeguard staff and the young people for staff to position themselves in view of CCTV. This will enable CCTV to be viewed and investigations to be completed.
- Ensuring that all staff have an understanding of the individual needs of the patients and how to adapt interaction styles to individual patients in order to support their recovery.
- Staff to be mindful of where and how they address upset family members, as this has the potential to cause further distress. Staff to be mindful of need to balance being discreet with meeting needs to appropriately supervise and observe patients when family members visit. Patient finance procedures are being reviewed to make the process easier for patients and family members to understand.
- Staff member will no longer be allocated to patient's observations.
- Whenever possible, ensure staff are familiar with ward and patients when delivering more invasive/distressing care such as NG feeds.
- Staff should follow approved MAPA techniques when carrying out physical interventions.
- Continue to follow patient's wishes regarding consent and family contact, whilst also ensuring staff are polite and respectful to family members who may try to make contact.
- Staff to support patient to finish phone calls with family appropriately and not to hang up without warning. Patients are not to pay for parking charges when on escorted leave in the community with staff members.
- A culture review has been initiated - Regular staff meetings take place - Members of the divisional triumvirate have spent time on the ward to speak to staff and observe interactions- There is a suggestion box on the ward for anyone wanting to remain anonymous- We have reviewed leadership on the ward and are in the process of making changes to increase visibility as the Ward Manager works three days per week.
- Training to ensure that all staff understand how to identify safeguarding concerns, how to record relevant information and who they escalate the concerns to for further follow up enquiries and actions. Consider installing CCTV in accommodation for RC and reducing the observation levels. Staff to observe CCTV from nursing office and respond according to risk. Consider ordering body cam for staff to wear when conducting observations or responding to alarms. Staff to be reminded to conduct

de-briefs after an incident. More staff to be trained to conduct de-briefs. De-brief templates to be uploaded to either DATIX or patient RiO. Senior member of staff on duty to ensure body maps are completed after restraint incidents and recorded on RIO or record on RIO that body map not completed due to no notable injuries. Improvement of staff rest room facilities and location of staff toilets

- Procedure for welcoming visitors onto the ward is being produced.
- Offer patients opportunity to take oral PRN before administering via IM injection.
- Staff are now aware of patient's wishes in how to be assisted if she falls.
- Care plan details that patient's support staff are to be at arm's length when in communal areas and that if patient or peers approach each other's door, colleagues will monitor the interaction and remind that it is part of the ward's expectations, that patients will not approach each other's bedrooms.
- Staff training regarding language and terms to use/avoid would benefit staff in being able to positively engage patients. Staff have been reminded of importance of communication to manage patient and carer expectations.

**Complaint theme -** Staff availability
**Lessons learned / improvements made -**

- Patient was worried about impact of staffing challenges on his progress in recovery, despite having unescorted ground leave. Communication about cancellation of leave due to Government lockdown was confused with staff challenges preventing leave - ensure clear communication is provided to patients when any changes to leave occur.
- Ensure timetable for daily tasks ensures that some staff members are still available to meet needs of patients at all times.
- In talks with the kitchen staff to improve the portion sizing and quality of food provided to the ward. Ensure patients are not given misinformation; be transparent when situations arise particularly around staffing, our patients become anxious and insecure if they feel there are problems on the ward. Explore the option of a more permanent Imam, AH's faith is important to him and causes him uncertainty when sessions are cancelled.
- Recent recruitment and current training of staff to be able to use British Sign Language should support patient's request for improved communication between patients and staff.
- Staffing levels are currently being reviewed on a regular basis. We aim to provide significant improvement to the care offered to patients with increased consistency and a greater number of permanent staff on each shift.
- Ensure correct neuro observations are undertaken following potential head injuries
- Processes have been changed on the ward to have a morning meeting and diary to arrange activity and leave. Patients are being involved in least restrictive practice initiatives on the ward.
- Use opportunities such as community meetings to discuss whether patients feel safe on the ward and to encourage conversations with ward staff if they are ever concerned about staffing levels.

**Complaint theme -** Staff competence
**Lessons learned / improvements made -**

- Staff require training to follow correct technique to deal with such emergency incidents safely

Table 8 contains some examples of learning in relation to specific complaints. However, it is clear that there is a great deal of general, Charity-wide learning to be gained from complaints. Key improvements identified include:

- Greater information sharing and improved communication needed with carers from point of admission through to discharge. The Carer Engagement Lead is supporting Divisions to improve their family and carer communication processes from time of admission through to discharge to meet CQC and NHSE Transform requirements. Much of the frustration and distress patients experience about their care is also a result of miscommunication or poor communication between staff and patients.
- Training and supervision needs have been identified for specific staff members
- Implementation of weekly updates with local authority safeguarding team
- Ensure patients are engaged from the planning stage of projects
- Need for patient property records to be accurately maintained and items stored securely
- Additional relational security training for ward staff across CAMHS and LSSR
- A process to instruct staff on the correct steps to follow after a patient death would assist families and carers as well as staff. This would need to cover all aspects including how to inform families and the legalities and processes regarding accessing a loved one's estate.
- Patients who have raised complaints about the use of restrictive practice have been invited to participate in the Least Restrictive Practice Patient Advisory Group.

## 5. Listening, Reviewing, Learning, Improving

5.1 Other sources of feedback

The PALS & Complaints Team forms part of the wider Patient and Carer Experience Team. Within the wider team, there are numerous ways in which we seek to gain feedback from patients and carers to ensure their voice is at the heart of all we do. Some of the patient and carer engagement activities we support include:

- BENS Forum, the Charity-wide patient and service user forum, attended by Trustees, Governors and senior members of the organisation to share updates on the organisation and have patients provide feedback on their experience;
- The Carers Advisory Group met online bimonthly, providing insight and support on issues that affect our carers, such as communication with families upon a loved one's admission. Meeting attendance dwindled over 2021/22 and so the group's purpose and operating procedures will be reviewed in 2022/23;
- Least Restrictive Practice Patient Advisory Group meets monthly to discuss restrictive practices with the aim to share good practice as well as highlight areas of concern.
- St Andrew's Coproduction Network meets bimonthly and comprises patients and staff from across the Charity. The aim is to share good practice and increase awareness of coproduction.
- In 2021/22 we launched 'My Voice', a coproduced patient reported experience measure (PREM) to provide a more responsive approach to feedback from patients about their experiences of care. The My Voice survey questions also include the Friends and Family Test questions.

5.2 Collaborative working

As part of the wider Patient and carer Experience Team, collaborative working across support functions and Divisions has been integral to both improving the efficiency of the PALS & Complaints Team and also in gaining important patient feedback on a range of issues. Examples of the past year's collaborative working includes:

- Colleagues in the Patient Safety and Investigations Team provided support in investigating more complex complaints, or those that required input from outside the Division. The quality of investigations produced by the team is significantly greater

that those produced within Divisions, namely due to the numerous competing priorities faced by Divisional staff.

- DATIX colleagues supported the development of a greatly improved recording process that not only streamlines the data input requirements to manage complaints, but also enables thorough scrutiny of themes from complaints, concerns and compliments, which will become evident in reports produced over the coming year;
- Colleagues within Business Management supported the roll out of the new DATIX form by ensuring that associated PARIS reports would still work as required by the PALS & Complaints Team;
- The Patient Engagement Team has supported many patients to interview job candidates to ensure that the patient voice is captured within the recruitment process so that we recruit staff that reflect the attitudes, values and attributes that our patients want from those who support them;
- We worked with the Infection Prevention and Control Team (IPC) to ensure the safe re-opening of the Carers Centre, enabling us to welcome carers back on site within COVID-19 guidelines. Our Patient Engagement Team also worked with IPC colleagues to gather patient feedback on a pilot of new cleaning wipes on one of the Neuro wards, as well as gathering feedback from patients on their preferred use of any ward isolation funds available;
- The Patient Engagement Team worked closely with colleagues from REDS Academy and patients to coproduce a 'coproduction skills' training course aimed at patients and members of staff, to equip them with the skills and confidence to coproduce care;
- The Patient Engagement Team has worked with Learning & Development colleagues to identify how the patient voice can be captured, and represented, in all training modules, both online and in person. Work will commence on this in 2022/23;
- The Patient Engagement Team worked with Communications colleagues to create short films featuring patients to be shared at Charity-wide events such as induction;
- Support given to progress a patient-led CQI project in which medium secure patients are supported by low secure patients to help prepare them for the transition to a lower level of security.

5.3 Complaints feedback

Gaining feedback from those who raise issues about their experience of the complaints process is a useful way of assessing the effectiveness of the PALS & Complaints Team. It enables us to review our processes and make necessary changes to try to improve satisfaction with people's experience of using the service. A significant theme at national webinars and conferences during the period was the difficulty healthcare organisations have in gaining such feedback once a complaint is resolved. There could be several reasons for this, including complainants' difficulties in separating their experience of the process from their level of satisfaction in the outcome. Additionally, there may be people who wish to 'move on' once a complete has been resolved and do not wish to spend any more time considering their complaint.

In May 2021, we introduced a new style of feedback form that was shared with people at the same time as they received their outcome letter. The feedback form was based on the 5 principles of the User Led Vision (My Expectations: Parliamentary and Health Service Ombudsman, Healthwatch, Local Government Ombudsman 2014), which are:

- I felt confident to speak up
- I felt making a complaint was simple
- I felt listened to and understood
- I felt that my complaint made a difference
- I would feel confident making a complaint in the future

The local resolution form has a mandatory field for the person who raised the complaint to complete and prompts staff to ensure they have considered and asked where appropriate, how the patient could be involved in driving change and learning identified as part of their complaint. During the year, of the 231 closed complaints, the team only received 8 feedback forms. All feedback indicated people felt the complaints process was simple and easy to follow, but a minority of feedback indicated people felt that their complaint made no difference.

The previous two years, the Annual Patient Survey included questions to gauge patients' knowledge of the complaints process and their experience of using it. In 2021/22, we introduced a new form of patient survey called 'My Voice', which is a type of patient reported experience measure (PREM). My Voice was coproduced with patients and seeks to gain feedback on a frequent basis so that we may be more responsive to patients' needs. To avoid confusion for patients, and to enable full focus on establishing My Voice, the decision was made not to hold the Annual Patient Survey 2021/22.

5.4 Complaints monitoring

The complaints process is closely monitored to ensure complaints and concerns are handled appropriately. The Complaints policy and associated procedures utilise a triage approach for different levels of complaints; the PALS, Complaints and Patient Engagement Manager and PALS & Complaints Officers triage each complaint. Recommendations are then made to the Division regarding local resolution or formal investigation.

DATIX holds a complete electronic record of the complaint history. Changes to the PALS & Complaints form on DATIX began in Q4, with multiple testing stages to ensure a 'go live' date of 4 April 2022 was possible. The changes to DATIX provide detail on the types of complaints and who made those complaints that will enable more robust analysis of trends, whilst also streamlining the data entry input required. This work further supports the accuracy of the Patient Safety Dashboard.

When sharing new complaints with the relevant wards and Divisions, the Charity Executive Committee members are copied into emails to provide them with oversight of the complaint topics that are being logged. All complaints response letters are reviewed and signed by the CEO, with all associated documents including the complaint, investigation reports, statements, local resolution forms, information provided by the service and consent forms if the complaint was made by a third party. The CEO will make amendments as they see fit, and will also query whether we can truly provide the assurances documented in response letters. This provides high-level oversight of the entire performance of the complaint and adds another level of quality assurance.

Heads of Nursing and Heads of Operations are asked to review response letters for their Divisions and Nurse Managers review responses for their wards. This enables them to identify any actions necessary as a result of the learning obtained from complaints. Each Division receives a monthly breakdown of their complaints activity, concerns and compliments. Until January 2022, complaints activity was supplied weekly to Divisions using a Red, Amber, Green (RAG) rating system that clearly highlighted actions required and also any areas of good practice. Work is planned to utilise DATIX dashboard functions to enable an automated and accessible for of this information for Divisions.

The Safeguarding Team is provided with a monthly breakdown of all complaints that are handled as Safeguarding. A monthly report of all complaints, concerns and compliments involving doctors is sent to the Revalidation Support Officer. A monthly report of complaints and concerns relating to restrictive practice is provided to the Restrictive Practice Monitoring Group with any additional training needs shared with Learning & Development. Complaints are also reported through the Quality & Safety Group and Court of Governors.

5.5 Monitoring Risk
The complaints risk register is reviewed monthly to ensure a high level of oversight is maintained and all mitigation action taken as required. Failure to apply learning from complaints has a residual medium risk rating. There continues to be ongoing work in creating a robust Charity-wide mechanism to monitor actions and learning from Complaints, Serious Incidents and Safeguarding, as described earlier. Relevant learning from complaints is shared with the Patient Safety Group. Local learning is highlighted to all Clinical Directors, Heads of Operations and Heads of Nursing in the monthly reports. They are expected to cascade this to their teams at Divisional Governance meetings, team meetings and supervision as required.

5.6 Investigating trends and identifying issues
Monthly Quality Team meetings provide an opportunity for the identification of common themes noted at ward, Divisional and Charity-wide level. Further work is required to ensure triangulation with Human Resources investigations and Freedom to Speak Up Guardians. The Charity is committed to the creation of a robust mechanism to monitor the implementation and success of action plans created from lessons learned. The DATIX record improvements will enable regular analysis of trends from complaints, concerns and compliments.

## 6. Staffing

6.1 Staffing levels
We currently have 2.03 FTE PALS & Complaints Officer (comprising 3 members of staff) and 1 FTE PALS, Complaints and Patient Engagement Manager (however their work on PALS and Complaints is equivalent to 0.6FTE with 0.4FTE spent on patient engagement). At the start of the period the team comprised a 0.8FTE Administrator and 0.43 PALS & Complaints Officer. A temporary contract of 6 months for 1 FTE PALS & Complaints Officer was fulfilled from June – November 2021. The Administrator role was reviewed and the post holder relocated in January 2022 and in January and March 0.6 FTE and 1 FTE, respectively, PALS & Complaints Officers started in post.

During the review period there were two occasions of long term sickness absence, in addition to training a temporary post holder. At times this significantly affected the team's ability to provide resolutions within agreed time frames. Where timescales could not be met, the team prioritised communicating with the appropriate individuals so they were kept informed of the progress of their complaint.

Since January 2022, the low number of complaints raised, in conjunction with the additional staff members present, has resulted in the successful completion of much of the backlog of complaints and concerns.

It is difficult to benchmark the PALS & Complaints Team size compared with those across other healthcare organisations due to the significant variety of patient populations covered (inpatient/outpatient provision, population/geography covered, acute/long stay services, etc.) Attendance at national forums has highlighted that in order to provide the most effective and responsive complaints processes from which significant improvements are identified and implemented, sufficient people resource is essential. This is mainly due to the need for sometimes lengthy conversations with patients or carers who wish to raise a complaint, to truly identify their concerns and ensure they are satisfied with the resolution.

6.2 Training

In June 2021 the team hosted a CPD event in collaboration with the PHSO that introduced St Andrew's staff to the new NHS Complaint Standards. The session explained the Standards and how we aim to establish a culture that welcomes feedback, empowers staff to resolve issues and learns from all types of feedback we receive. The Complaints and Feedback e-learning module was launched at the end of the 2021/22 year.

## 7. Key priorities for 2022/23:

Many of our priorities for the coming year are focused on embedding the New NHS Complaints Standards, with a focus on nurturing a culture that not only welcomes, but also actively encourages, feedback.

Complaint process

- We will be fully implementing and embedding the new NHS Complaint Standards, as created by the PHSO in conjunction with stakeholders across the NHS and independent healthcare sector. The updating of policy, procedure and associated document templates was postponed in 2021/22 due to team constraints.

Staff training

- Fully induct and train new PALS & Complaints Officers.
- Communications campaign needed to encourage completion of the Complaints and Feedback and Carer Engagement e-learning modules for all patient-facing staff.
- Offer face-to-face complaints and feedback awareness sessions to wards and/or Divisions.
- Work will commence on capturing the patient voice to be included in and to influence all relevant training modules across the Charity, with the aim to co-deliver training where possible.

Improving efficiency and effectiveness

- Develop closer working relationships with ward staff with the aim to empower them to welcome feedback as an opportunity to learn and to have the confidence to address issues directly as they arise.
- Increasing presence across all areas of the Charity through drop-ins and awareness campaigns.
- Creating more opportunities for patients to provide feedback through the various patient forums across the Charity by introducing clearer guidance on the purpose of each type of forum, with clear escalation processes for the resolution of any issues raised.
- Aim for 90% of cases to be concluded within agreed timescales. The new Standards introduce a more tailored approach to assigning timescales upon receipt of a complaint, making this goal more achievable than it has been when working within a general 30 working day timeframe.
- Support ward colleagues to increase the number of complaints resolved at the first stage and reduce the number of formal investigations required. This allows for quicker resolution of issues.

Improve reporting processes

- Development of automated reporting process utilising DATIX dashboards, enabling Divisions and wards to review progress of complaints and actions required.

- Introduction of complaints element for use on the Integrated Performance Review dashboard.

Quality assurance

- Introduce peer group reviews of anonymised complaints responses. The group will comprise staff, patients and Governors.
- Review methods for gaining feedback from patients and carers to measure level of satisfaction and to inform improvement and development within the complaints process.
- Ensure monthly monitoring of the risk register for the complaints process.
- Support work being done at Charity-wide level to implement robust process for identifying lessons learned, then implementing and monitoring effectiveness of any changes made as a result.

## 8. Conclusion

The year 2021/22 saw the Charity and the PALS & Complaints Team continue to strive to provide high quality services in the face of numerous challenges.

- Temporary resource deficits brought on by vacancies and long term sickness absence led to backlog of complaint responses and high level of overdue complaints, as well as inability to provide drop-ins.
- Full implementation of the new NHS Complaints Standards was delayed to 2022/23.
- Work on DATIX complaint records was postponed due to necessary work on the Risk module of DATIX. Work has now been completed and benefits will be seen in 2022/23 in relation to providing more thorough analysis of complaint themes.
- We have developed networks with other organisations and national forums to ensure that we share good practice. We have developed good connections with the PHSO, who supported the delivery of a complaints focused CPD event in June 2021.
- We have continued to develop internal relationships across all services to ensure the best possible outcomes for the people raising complaints and concerns.
- We have experienced an increase in complex, multi-faceted complaints that require greater levels of coordination and investigation.
- We have looked for opportunities to empower and enable patients to meaningfully influence and participate in the work of the Charity by providing their feedback.
- The Charity remains committed to thoroughly investigating, learning from and taking action as a result of individual complaints. Where it is found that standards have fallen below the level we expect and where services could be improved, we will take action to resolve the issues identified and involve the person who raised the complaint in these changes as far as is possible.
- We will continue to improve how complaints are handled across the Charity, through the implementation of the new NHS Complaint Standards and continued monitoring of all complaints to ensure where questions are raised about the quality of care we deliver, they can be quickly investigated and responded to.

**Report for the Board of Directors**
**Annual Mortality Report (Learning from Deaths) April 2021 - March 2022**

This report considers the data from 1 April 2021 to 31 March 2022 inclusive. There have been a total of 10 deaths within the Charity during this period in comparison to 27 deaths in the previous year. This highlights the effects of Coronavirus pandemic in the previous year reflective of the increase in the numbers of deaths across the country.

This document is presented to the Board of Directors, to provide assurance regarding the efficacy of the Learning from Deaths (LFD) process, in line with the National Quality Board (NQB) guidance on learning from deaths (March 2017). The expectation from the NQB guidance is for the Charity to collect and publish information on deaths to generate learning.

All expected deaths were subject to the mortality review process, using a structured judgement review tool. Serious Incident (SI) investigations, using root cause analysis methodology, were undertaken where the death was unexpected or where it was felt that it was possible to gain more in depth organisational learning. As per policy and procedure, the CQC and relevant commissioning bodies are notified in the case of all deaths. Total summary figures are as follows:

**Table 1: Total deaths review process 2020/2021**

| Total Deaths | Deaths associated with Covid 19 | Deaths investigated only through the SI process | Deaths reviewed only through the mortality review process | Deaths reviewed through both the mortality review & SI process |
|---|---|---|---|---|
| 10 | 3 | 0 | 7 | 3 |

**Table 2: Deaths summarised**

| Patient | Age | Gender | Ward | Date of death | End of life care plan | Resuscitation status at the time of death | Diagnosis | Cause of death | Mortality review or SI process |
|---|---|---|---|---|---|---|---|---|---|
| **1** | 58 | M | Cranford/ NGH | 01 Apr 21 | Yes | Not for resuscitation | Schizoaffective disorder | Hepatic Encephalopathy hepato-renal syndrome. Cirrhosis. Hepatitis C Pneumococcal pneumonia | MR |
| **2** | 70 | M | Elm Ward | 22 Jun 21 | Yes | Not for resuscitation | Pick's disease | Bronchopneumonia, Pick's disease, asthma,frailty | MR |
| **3** | 73 | M | Elm Ward | 08 Jul 21 | Yes | Not for resuscitation | Unspecified dementia, Organic personality disorder | Advanced dementia, Severe frailty | MR |
| **4** | 63 | M | MoorGreen/ QEH | 11 Jul 21 | Yes | Not for resuscitation | Schizoaffective disorder | Pneumothorax, COPD, asthma, **COVID 19 pneumonia** | MR + SI |
| **5** | 71 | M | Redwood | 05 Oct 21 | Yes | Not for resuscitation | Unspecified dementia | Severe Frailty, Advanced Dementia | MR |
| **6** | 61 | M | Danbury | 08 Nov 21 | Yes | For resuscitation | Paranoid schizophrenia | **COVID 19 pneumonia** | MR + SI |
| **7** | 48 | M | Danbury/ Basildon GH | 11 Nov 21 | Yes | Not for resuscitation | Paranoid schizophrenia, Dissocial personality disorder | **COVID 19** | MR + SI |
| **8** | 54 | M | Berkeley Close GF/ NGH | 27 Nov 21 | Yes | For resuscitation | Paranoid schizophrenia/stroke | Aspiration Pneumonia | MR |
| **9** | 62 | M | Hawksley/ QEH | 12 Dec 21 | Yes | Not for resuscitation | Schizoaffective disorder | Awaiting coroners report but hx of diabetes, hypertension, heart failure, | MR |
| **10** | 81 | M | Elm | 8 Jan 21 | Yes | Not for resuscitation | Vascular dementia | Lower respiratory tract infection, diabetes, frailty | MR |

**Summary of Findings**

Overall Findings

- There was a reduction in number of deaths this year (10) in comparison to previous year (27).
- 3 deaths were related to Covid19 as the principal or contributory cause of death and these were subjected to SI investigations.
- None of the deaths subjected to mortality reviews or SI investigations were judged to be more likely than not, to have been due to problems in the care provided in the patient.
- There was good evidence of integrated care and active relationships with advocacy services and external experts including the Palliative Care Team.
- There was evidence of supportive relationships with families, supported by positive feedback in majority of the reviews.

Case specific findings

- Patient 8 – Revision of consent to share information care plan needed in patient who declined involvement of family. It identified need for prompt communication with family following death of the patient by an appropriate member of the MDT. Recommendation that capacity to consent to DNACPR should be led by a medical or senior member of the MDT and the end of life procedure has been updated to reflect this.

**Improvement Opportunities**

**Table 5: Learning and actions taken**

| Learning Theme | Action Taken | Assurance process |
|---|---|---|
| Need for identification of patients at risk of deterioration in physical health. | Frailty assessment is now mandatory for all patients >65 and communicated to all medical staff | Automatic referral for all patients >65 without frailty index to the medical team |
| Lack of documentation regarding capacity assessments for patients to consent to physical healthcare interventions | Revision of current consent policy to highlight processes for;<br>-patients who decline physical care interventions<br>-patients declining consent to share information with family | Assurance process to ensure capacity assessments to be completed for all patients declining physical healthcare interventions |

| | | |
|---|---|---|
| Capacity assessments regarding DNACPR | End of life procedure updated to ensure DNACPR discussions are led by medical or senior MDT members | Liaison with divisional leadership teams. |
| To ensure End of Life care plans include plans for funeral arrangements and who should be should be contacted and by whom | End of life policy to be updated and communicated to all MDTs To be included within the review of consent policy | Mortality review process in place using the standardised judgement tool with involvement of the family liaison officer |

**Summary of report**

There were 10 deaths during 1 April 2021 to 31 March 2022, compared to 27 deaths the previous year. Covid 19 infection was a cause or contributory factor in 3 of deaths across the year.

All deaths were subject to a mortality review, a serious investigation process or both. Key learning was related to improve recording of capacity assessments with DNACPR, physical health monitoring, and ease of contact for family members. Actions related to these have been completed or initiated with review and monitoring processes put in place to provide ongoing assurance. Areas of good practice of note related to integrated care, communication and liaison with families and external agencies.

**Recommendation**
The Board of Directors is asked to consider and approve this report.

# Infection Prevention & Control Annual Report – 2021-2022

# Contents

## Table of Contents

# Executive Summary

This has been another unprecedented year in healthcare with the continued coronavirus pandemic having a huge impact across the Charity.

Andy Brogan DIPC/Chief Nurse

I am pleased to report the appointment of Pixy Strazds as Deputy Director for IPC in November 2020 and 3 new IPC Practitioners appointed November and January 2021. An administrator who joined the team March 2021 supports the team.

The team have responded to the fast changing national situation providing guidance and support to clinical areas.

The team have worked tirelessly to improve IPC standards across the Charity and give assurance to both the Charity and our external stakeholders.

Throughout the year NHSEI have supported the Charity, monitoring our response to the pandemic. This has led to the current NHSEI support reduction to Amber for our Northampton site and the team are expecting an Amber rating following and NHSEI inspection in May 2022 for Birmingham.

This year the Infection Prevention and Control Annual Report continues to follow the format of the Health & Social Care Act 2008 (updated 2015) to demonstrate our progress with the requirements associated with the criteria of the Act.

The report demonstrates that St Andrew's Healthcare, assisted by the new IPC service, continued to make substantial progress throughout the year in providing assurances to the Board.

# Executive Summary continued

The priorities and future developments are –

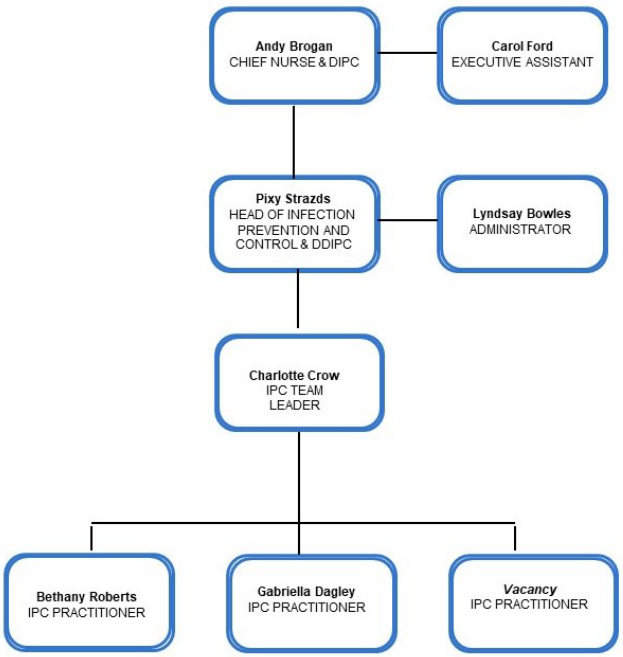
- Auditing – Bringing iAuditor in to improve our audit system.
- Patient Involvement – Working with carer engagement and ward teams to encourage patient involvement.
- Working with NHS England  to achieve green status.

As the continued pandemic maintains the focus for IPC, and healthcare as a whole, we can all be justifiably proud of our response. Between mid-December 2021 and end January 2022 saw the IPC team support the Charity managing 26 active outbreaks.

None of this could have been achieved without the positive engagement from staff for which we are truly thankful and appreciate their continued vigilance.

# Introduction

St Andrew's Healthcare recognises the obligation placed upon it by the Health & Social Care Act 2008 (updated 2015). The Charity majorly invested in the Infection Prevention and Control (IPC) service leading to the new structure below.




This annual report will reflect the changes following the creation of the new IPC service and seeks to assure the Charity Executive Committee (CEC) and Board of Trustees of the progress made to ensure compliance with the Health & Social Care Act 2008 (updated 2015). This report will also identify key priorities for 2022/2023 to continue improvements identified in the Annual Work Plan and provide the Charity with a Board Assurance Framework.

This Annual Report fulfils the legal requirements of section 1.1 and 1.3 of the Health & Social Care Act 2008 (updated 2015) and complies with the Care Quality Commission (CQC) Code of Practice.

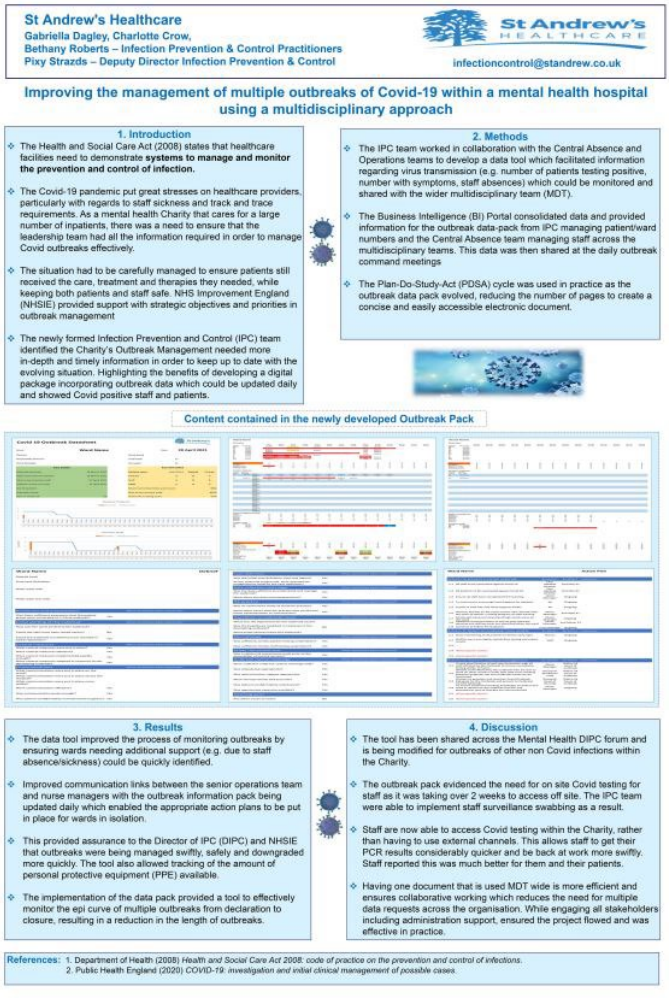
## 10 Criterion of the Health and Social Care Act 2008

**1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them**

Back in December 2020, the IPC team introduced our Outbreak data pack, which improved communication links between senior operations and nursing teams with the relevant information related to the outbreak to ensure appropriate action plans were put in place. The implementation of the data pack provided us with a tool to effectively monitor the epi curve of a number of outbreaks from declaration to closure, which then resulted in a reduction in the length of outbreaks.

The outbreak data pack was turned into a successful Continuous Quality Improvement (CQI) project, and following on from this, in September 2021, the data pack was submitted in poster form for the Infection Prevention Society (IPS) annual conference, which was on display for nationwide peers to review.

On our outbreak meetings within St Andrew's, we welcome external stakeholders from UKHSA and NHSEI who are able to provide us further input. On these meetings, it has been widely discussed positively by the Northampton CCG and as a result of this, the data pack has been shared within the whole health economy in the midlands.



**1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them**

In September 2021, in line with current guidance, the IPC team launched a COVID-19 PCR swabbing regime for patients who go on regular home leave. This enabled patients who regularly go on leave for over 24 hours to have a PCR swab once a week, which meant they would not have to isolate each time on their return to the ward as this regime provided the IPC team with regular assurance of negative tests. As a result of this, the regime improved patients' recovery and promoted health and wellbeing.

As part of our annual work plan (2021-2022), the IPC team reinstated the infection control link nurse programme where we asked nurse managers to identify a member of staff with an interest in IPC who would like to take on the role for their ward/area. In October 2021, we held a two day training programme which covered many areas of infection control including the science of IPC, risks associated within IPC and transmission based precautions. This enabled us to provide the link nurses with information and knowledge on various aspects of IPC to equip them within their role on the wards. We also used this as an opportunity to distribute IPC folders for each ward, which contained lots of relevant information including cleaning standards, flow charts for processes such as outbreaks and assessment tools. We also gave each link nurse a competency document to work through to support their development within their own practice.

In January 2022, following a visit from NHSEI, St Andrew's Northampton site was downgraded from red to amber in relation to IPC practice. We remain working closely with them to further improve. Our next step in this is St Andrew's Birmingham site are due to be visited in May 2022.

## 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

### Baseline Audits

Following the standardisation for annual IPC audits of clinical practice and the environment, the IPC team devised five 'rapid IPC' audits to further provide baseline data on areas requiring improvement. These cover the main areas relating to the Charity's Infection Control Policy, based on NICE guidance and ensuring compliance with The Health and Social Care Act 2008. Uniform, Sharps Disposal, Waste Management, Patient Equipment and a combined Hand Hygiene/Social Distancing/PPE audit provide an overview of practice and processes being maintained on the ward. The results as shown below are presented to the IPCG on a bi-monthly basis, where Heads of Nursing can review any areas of non-compliance and work with the IPC team to drive improvement. These audits should be completed on a monthly basis by the Nursing teams, IPC Link Nurses or IPC Practitioners, with scope to use these during 'spot check' visits.

| ID | Start time | Completion time | Email | Name | Ward Name | Division | Hand wash sinks are dedicated for that purpose only and are clean and unobstructed | Liquid/foam soap are single use cartridge dispensers | Dispenser nozzles are visibly clean | Soft absorbent paper towels are available at all hand washing sinks | Alcohol hand rub is available | Laminated posters promoting hand decontamination are available and displayed | Staff are compliant with 'Bare Below Elbow' (Observe 3 staff) | Staff use the correct 13 step procedure for decontaminating hands (Observe 3 staff) | Staff are compliant with the WHO 5 moments for hand hygiene (Observe 3 staff) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 8/31/21 15:38:11 | 8/31/21 15:40:15 | BKRoberts@stan | Bethany Roberts | Sitwell | | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; |
| 2 | 9/6/21 8:45:32 | 9/6/21 8:46:33 | BKRoberts@stan | Bethany Roberts | Hurst | | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; |
| 3 | 9/20/21 13:30:47 | 9/20/21 13:32:47 | CGCrow@standr | Charlotte Crow | Winslow | | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | No;2 staff with wrist watches and long sleeves; | Yes; | Yes; |
| 4 | 9/24/21 8:57:55 | 9/24/21 9:01:28 | BKRoberts@stan | Bethany Roberts | Spencer South | LSSR | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Unable to observe due to lack of staff; | Yes; |
| 5 | 9/24/21 9:23:09 | 9/24/21 9:24:15 | BKRoberts@stan | Bethany Roberts | Speedwell | Birmingham | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; |
| 6 | 10/14/21 8:58:22 | 10/14/21 9:00:36 | CGCrow@standr | Charlotte Crow | Willow | Medium | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | No; | No; | Yes; |
| 7 | 10/14/21 9:00:40 | 10/14/21 9:39:16 | CGCrow@standr | Charlotte Crow | Bracken | Medium | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | No; | No; |
| 8 | 11/7/21 15:25:18 | 11/7/21 15:32:07 | SAHogan@stand | Siobhan Hogan | Upper Harlestone | Low secure and spe | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | Yes;1 of the 3 staff members was wearing a jumper, encouraged to removed and they | Yes; | Yes; |
| 9 | 11/16/21 12:42:07 | 11/16/21 12:43:50 | BKRoberts@stan | Bethany Roberts | Hazelwell | Birmingham | Yes; | Yes; | Yes; | Yes; | Yes; | Yes; | No; | Yes;Only 1 staff observed; | Yes; |
| 10 | 11/16/21 12:48:27 | 11/16/21 12:49:44 | BKRoberts@stan | Bethany Roberts | Speedwell | Birmingham | Yes; | Yes; | No; | Yes; | Yes; | Yes; | No; | Yes; | Yes; |
| 11 | 11/16/21 12:50:02 | 11/16/21 12:50:55 | BKRoberts@stan | Bethany Roberts | Hawkesley | Birmingham | Yes; | Yes; | No; | Yes; | Yes; | Yes; | No; | Yes; | Yes; |

**2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**

## Collaborative Working

The IPC team have continued to build on effective working relationships, with a monthly meeting now held between the IPC team and Housekeeping Team Leaders. Any issues or concerns can be raised and discussed between the teams to find a solution, or escalate appropriately, improving timely and effective communication. This is furthered with a monthly Waste Management meeting and attendance at the Water Safety Group.

## Sharps Management

In November Daniels Healthcare kindly undertook an audit of our sharps disposal across all three sites and community services. Through procurement we have been able to standardise the Sharps Bins in use, enabling compliance with the EU Sharps Directive. We hope to roll out wall mounted brackets in the coming year, reducing risks associated with storage at floor level.


## NHS Cleaning Standards

Following the roll out of the new NHS Cleaning Standards by NHS England in 2021, the Soft Facilities team have been working extremely hard to re-categorise clinical areas in line with changes, with audits amended to reflect these changes. There will be new Star Ratings displayed at ward entrances, providing information to patients, staff and visitors on the overall cleanliness of the environment. The IPC team has been working to support these changes and implement them effectively.

## 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Information on antimicrobial use is supplied in chart form to the Medicines Management Operational Group (MMOG) and is available to be shared with pharmacists in their divisions to highlight any particular concerns such as type of antibiotics in use, areas with high use etc. Antimicrobial use follows a similar pattern each month but any unusual patters are discussed and looked into.

The Head of Pharmacy is a member of the Northants Antimicrobial Group so has opportunity to have access to secondary and primary care related antimicrobial initiatives and priorities.

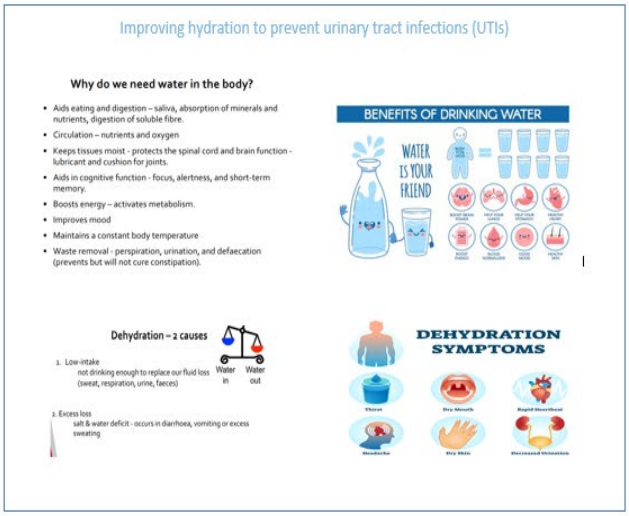
**4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion**

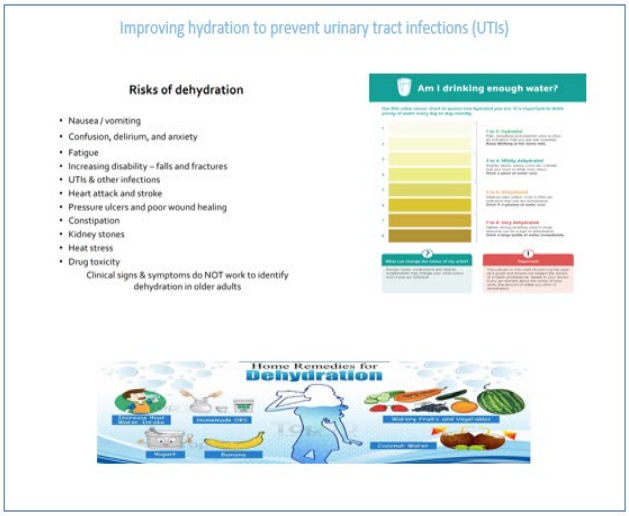
There is now a dedicated Infection Prevention and Control section on St Andrew's external website. This is where service users, their visitors and anyone providing support can easily access up to date National Guidance and the Charity's information on infections and the current IPC measures in place. The IPC annual report is also available online. There is information on how link nurses assist in delivering nursing/medical care to promote good infection control practice.

The IPC team have provided information to service users and visitors to the Charity through various formats which have included creating a visitor questionnaire to screen for COVID and a poster with guidance on '*COVID tips on hugging safely'*. We have also created an IPC folder, which is available on every ward in an easy to read format. Ward information boards have been updated to display appropriate IPC information for service users.

IPC have been liaising with the patient engagement team to create a patient evaluation form for an upcoming trial on using new cleansing wipes to enable us to get service user feedback.

In addition, the IPC team took part in promoting good health during Nutrition and Hydration Week for service users and staff.



**4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion**

Moving forward IPC would like to engage Patient Champions in the use of the patient experience tool and the Patient Environment Action Team (PEAT) to carry out hand hygiene and environment audits for their areas. The IPC team will also engage with the ward community meetings and patient forums.

The Carer Engagement Team liaised with the IPC team regarding the re-opening of the Carers Centre to family and friends of patients and service users. The IPC team provided guidance on how to continue to provide a welcoming environment within COVID-19 guidelines. Resulting changes to practice include the introduction of single use coffee and sugar sachets to minimise risk of cross contamination, as well as Carers Centre staff being encouraged to make drinks for visitors rather than them helping themselves.

The IPC team worked with the Patient Engagement Team to seek patient and service user feedback on how they would want any ward isolation grant money to be spent following wards being in isolation. They also worked with the Patient Engagement Team to seek feedback from Neuro patients on a new type of Clinell wipe that was being piloted on a ward. Patients and staff coproduced the questionnaire that was then used to seek patient feedback.

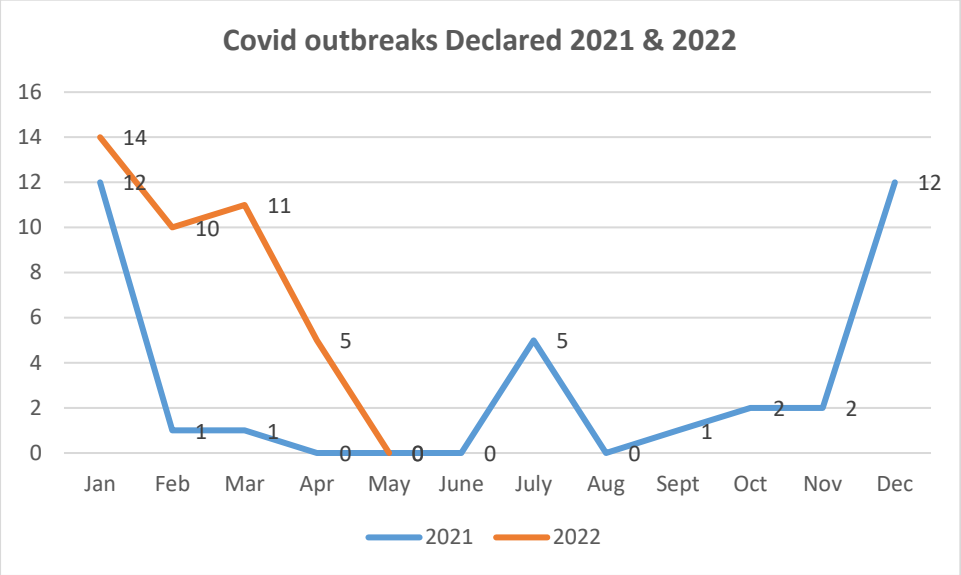
**5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**

## Overall IPC Datix for St Andrew's April 2021 – March 2022

| Type of incident | Number |
|---|---|
| Bitten – broken skin | 36 |
| COVID-19 confirmed | 133 |
| COVID-19 suspected | 46 |
| Diarrhoea and/or vomiting | 38 |
| Needlestick | 3 |
| MRSA | 1 |
| UTI | 2 |
| Risk of contamination | 69 |
| Other IPC | 35 |

## Number of COVID-19 outbreaks – April 2021 - March 2022: 57

Over the period 1st April 2021 to 31st March 2022 we have managed 57 outbreaks across the charity. From mid-December 2021 to end January 2022 we saw a peak with 26 outbreaks. The chart below shows a comparison of outbreaks in 2021 and 2022.



**5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**

When an outbreak has been declared, we have been undertaking onsite PCR surveillance screening for patients, which is processed by the local acute NHS hospitals – swabbing is undertaken by either the on-site physical health team or ward nursing staff; the IPC team then access the results and monitor.

We have also been able to provide on-site PCR surveillance testing for members of staff that have been identified as close contacts during an outbreak. This has ensured that staff are tested in a timely manner and we can be reactive to results.

## Lateral flow tests

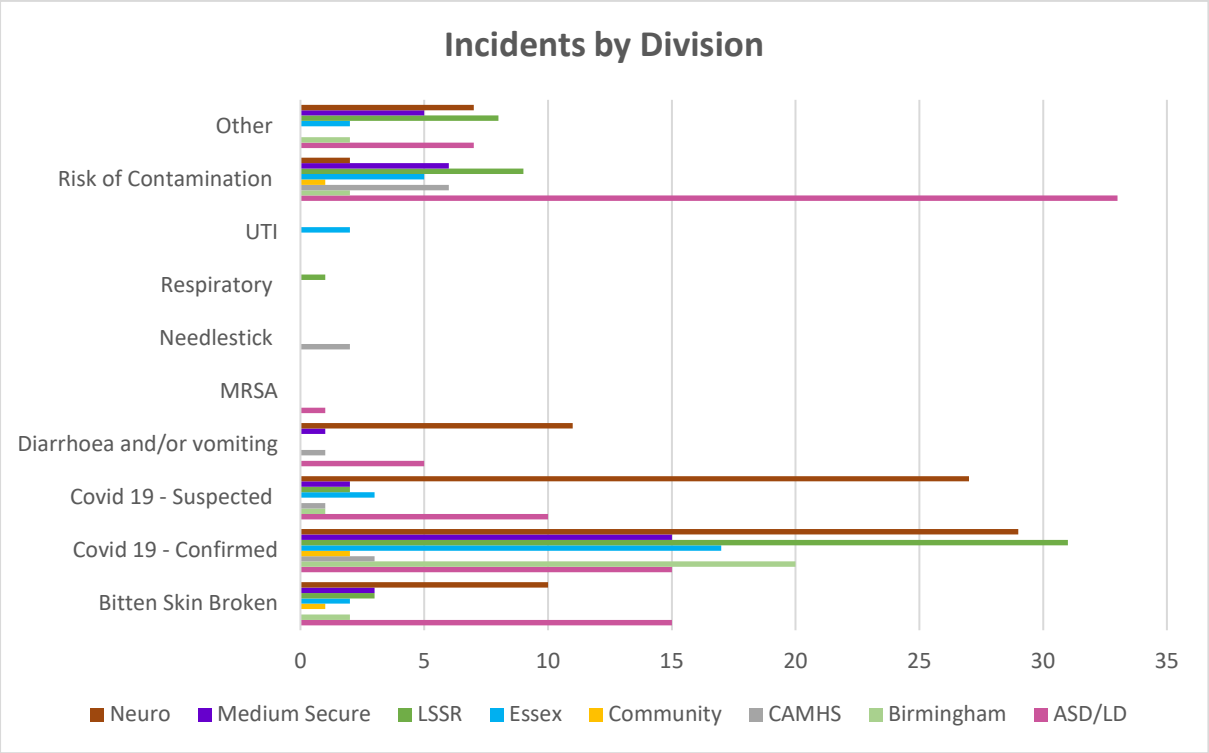
As there is a requirement for staff to complete twice weekly COVID-19 testing, lateral flow tests have been made readily available on site to all St Andrew's staff and there is an internal database where staff results can be uploaded to ensure easy identification of positive results.

Lateral flow testing has been monitored through COVID command.

**5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people**

## Incidents by Division

The chart below shows the incidents by division throughout the year.



## 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

### Training

The IPC team continue to deliver face to face training on Induction of new employees. We have reviewed the mandatory IPC E-Learning this year to ensure it is in line with best practice, stipulating roles and responsibilities.

During the year 822 new employees started with the Charity.

The table below shows the percentage of staff within each division who have completed IPC E-Learning.

| Infection Control completions as at 28/03/2022 | | Infection Control - Clinical and Non-Clinical in a Clinical Area | | Infection Control Non-Clinical | | | |
|---|---|---|---|---|---|---|---|
| Division | Target | Complete | % | Complete | % | Total Completions | Total % |
| Finance | 40 | 0 | 0.00% | 39 | 97.50% | 39 | 97.50% |
| Human Resources | 139 | 22 | 15.83% | 116 | 83.45% | 138 | 99.28% |
| IT Services | 40 | 1 | 2.50% | 36 | 90.00% | 37 | 92.50% |
| Education | 39 | 38 | 97.44% | 1 | 2.56% | 39 | 100.00% |
| Workbridge | 25 | 25 | 100.00% | 0 | 0.00% | 25 | 100.00% |
| Community Services | 71 | 67 | 94.37% | 0 | 0.00% | 67 | 94.37% |
| Estates | 387 | 302 | 78.04% | 81 | 20.93% | 383 | 98.97% |
| Executive Medical Directorate | 39 | 31 | 79.49% | 6 | 15.38% | 37 | 94.87% |
| Academic | 18 | 10 | 55.56% | 8 | 44.44% | 18 | 100.00% |
| Operations | 9 | 5 | 55.56% | 3 | 33.33% | 8 | 88.89% |
| Strategic Partnerships | 37 | 6 | 16.22% | 31 | 83.78% | 37 | 100.00% |
| Community Partnerships | 62 | 48 | 77.42% | 13 | 20.97% | 61 | 98.39% |
| ASD and LD | 631 | 602 | 95.40% | 2 | 0.32% | 604 | 95.72% |
| Birmingham Division | 425 | 411 | 96.71% | 7 | 1.65% | 418 | 98.35% |
| CAMHS | 204 | 196 | 96.08% | 0 | 0.00% | 196 | 96.08% |
| Medium Secure Mental Health | 489 | 471 | 96.32% | 2 | 0.41% | 473 | 96.73% |
| Low Secure and Specialist Rehab | 403 | 395 | 98.01% | 2 | 0.50% | 397 | 98.51% |
| Essex Division | 295 | 281 | 95.25% | 7 | 2.37% | 288 | 97.63% |
| Neuropsychiatry | 541 | 521 | 96.30% | 3 | 0.55% | 524 | 96.86% |
| Quality & Nursing | 88 | 59 | 67.05% | 29 | 32.95% | 88 | 100.00% |
| **Charitywide Total** | **3998** | **3495** | **87.42%** | **394** | **9.85%** | **3889** | **97.27%** |

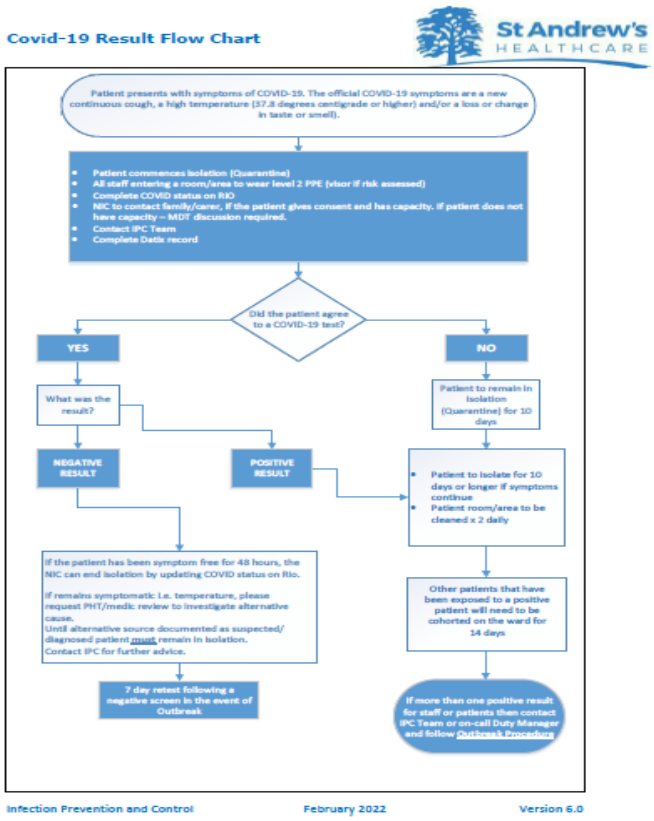
During Outbreaks of COVID-19 we found that staff needed access to key information on IPC Practice at the point of care. To address this the IPC team would make early contact with the Nurse Manager, providing resources such as a printable version of the ‘supertraining’ that can be accessed by all staff including non-permanent staff.

## 7. Provide or secure adequate isolation facilities

The IPC team have had to continuously adapt COVID isolation guidance in line with UKHSA and NHSEI recommendations. The team produced isolation algorithms to reflect changing isolation requirements which were disseminated across the Charity.

IPC also identified that the isolation provision for COVID positive patients needed to be adapted in some of the low secure specialist rehab units which do not have bedrooms with ensuite facilities. Therefore, an empty ward was used to isolate positive patients to prevent cross-transmission and enable staff to provide care in a safe and secure environment.

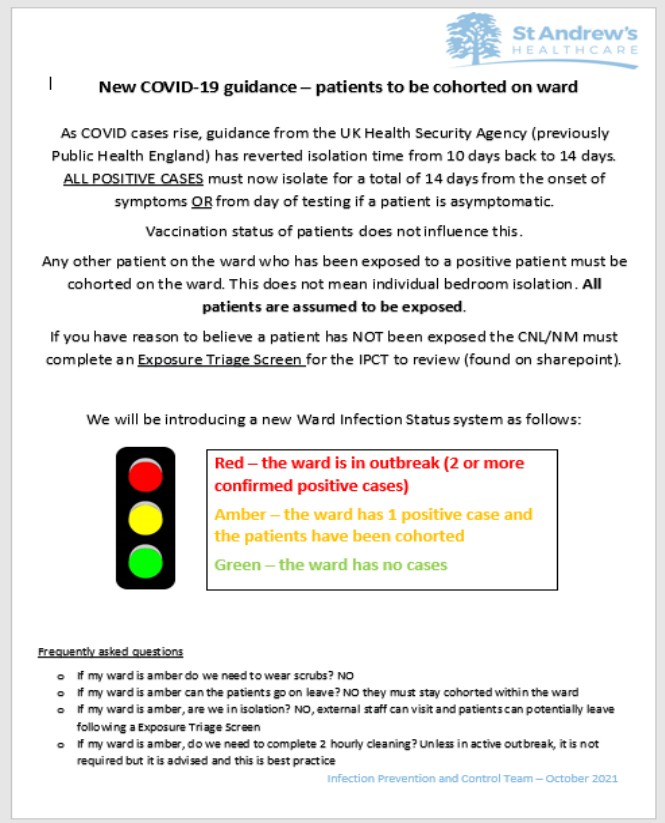
Below is an example poster produced by the IPC team in relation to changing guidance.



## 7. Provide or secure adequate isolation facilities

Protective reverse isolation procedures have been followed with staff and visitors wearing barriers i.e., masks, aprons and gloves where necessary to prevent client exposure to external microbes.

The IPC team created a ward 'traffic light' protocol to clearly indicate infection status for staff and visitors to the ward. This facilitated an additional step in the isolation process as a ward with 1 positive case could cohort patients (amber) which was less restrictive than a ward being in outbreak (red) as visitors were still allowed onto the ward.



St Andrew's HEALTHCARE

**New COVID-19 guidance – patients to be cohorted on ward**

As COVID cases rise, guidance from the UK Health Security Agency (previously Public Health England) has reverted isolation time from 10 days back to 14 days. ALL POSITIVE CASES must now isolate for a total of 14 days from the onset of symptoms OR from day of testing if a patient is asymptomatic.

Vaccination status of patients does not influence this.

Any other patient on the ward who has been exposed to a positive patient must be cohorted on the ward. This does not mean individual bedroom isolation. **All patients are assumed to be exposed.**

If you have reason to believe a patient has NOT been exposed the CNL/NM must complete an Exposure Triage Screen for the IPCT to review (found on sharepoint).

We will be introducing a new Ward Infection Status system as follows:

**Red – the ward is in outbreak (2 or more confirmed positive cases)**

**Amber – the ward has 1 positive case and the patients have been cohorted**

**Green – the ward has no cases**

Frequently asked questions

- If my ward is amber do we need to wear scrubs? NO
- If my ward is amber can the patients go on leave? NO they must stay cohorted within the ward
- If my ward is amber, are we in isolation? NO, external staff can visit and patients can potentially leave following a Exposure Triage Screen
- If my ward is amber, do we need to complete 2 hourly cleaning? Unless in active outbreak, it is not required but it is advised and this is best practice

Infection Prevention and Control Team – October 2021

## 8. Secure adequate access to laboratory support as appropriate

Laboratory support for St Andrew's is provided by the local acute NHS hospitals in the respective area. The hospitals used are Northampton General Hospital (NGH), Birmingham – Queen Elizabeth (QE), Nottinghamshire – Kings Mill Hospital (KMH) and Essex – Basildon Hospital (BH). The Infection Control Lead liaises with them to discuss microbiological sample results and antibiotic sensitivities.

Physical Healthcare are currently reviewing all SLAs for pathology and microbiology and the DDIPC is part of the review panel.

## 9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections

This has been a challenging year for healthcare due to the ongoing COVID-19 pandemic. The IPC team have kept up to date with changes to national and local procedures through regular contact with UKHSA and our NHSEI colleagues, producing Standard Operating Procedures and time specific guidance to control infections whilst providing operational processes as reflected earlier in the Annual Report.

The IPC team reviewed all of the Policies and Procedures this year, cross referencing against NICE Quality Statements, current Clinical Evidence and Systematic Reviews to ensure these reflect best practice. This has included the first major review and update of MRSA guidance in over ten years.

COVID-19 has also brought to our attention the need to differentiate guidance based on the setting and nature of care provided. Adult Social Care, Outpatient and Inpatient services have different risks associated to them and the IPC team have applied guidance in the least restrictive way whilst complying with regulators and advisory stakeholders.

The IPC team await the NHS England National IPC Manual due April 2022.

## 10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

### Covid Boosters and flu vaccines

Throughout the winter, all staff were encouraged to have their COVID-19 booster and flu vaccines with bookings and drop in sessions offered across the St Andrew's sites. For any staff who had not yet had 1st and/or 2nd COVID-19 vaccinations they could have these through St Andrew's also.

The IPC team assisted as vaccinators at the Northampton site during this period.

### FFP3 Fit Testing

The IPC team continue to carry out fit testing of FFP3 masks for staff that require additional level 3 personal protective equipment. To date 231 staff across the Charity have been successfully fit tested for FFP3 masks.

## Achievements 2021/2022

**Some of the achievements by the IPC team during the year.**

## Priorities and Future Developments for 2022/2023

- **Auditing –** We are bringing in iAuditor during June 2022 to capture consistent data from our audits, to help identify areas of improvement and share reports in real time with the clinical staff.

- **Patient Involvement** - Continue working with the carer engagement team and ward teams to include patients in product analysis and audits such as those for hand hygiene and cleanliness

- **Working with NHS England** – To give assurance on IPC practice and compliance with the Health and Social Care Act. Working to achieve green status. Review dates from NHS England are due for late summer.

# Committee Update Report to the Board of Directors

## Name of Committee: Audit and Risk Committee

## Date of Meeting: 21 July 2022

## Chair of Meeting: Elena Lokteva

## Significant Risks/Issues for Escalation:

- The Committee acknowledges that it retains an overall "Partial" assurance rating for the risk management system, recognising however that it feels "Substantially" assured by the effort, application and effectiveness of the Risk Team and Senior Management in improving the risk management process and approach. The wider system assurance level is expected to improve over time, once the impact of the improvements and work being done is seen and measured through the newly introduced KPIs.
- The there is a risk that Board subcommittees don't allocate adequate time for BAF risks scrutiny. This will delay the positive impact of BAF in strengthening our governance.

## Key issues/matters discussed:

1. Grant Thornton

Grant Thornton presented the committee with an update on the progress against the external audit plan. The plan is generally on track, with three of the four Key Risk areas now reviewed, with Going Concern to be looked at later in the audit as planned. A list of remaining key deliverables was highlighted and discussed and an initial list of key findings to date was also highlighted, however none were material in nature. Further work where required is in hand and will be included in the final report and provided at the ARC, with clarity over where the findings relate to a differing of approach to previous audits. The completed "Informing the audit risk assessment" (completed by management) was also shared and Grant Thornton confirmed findings will be presented in October Committee meeting.

The Committee were satisfied with the progress being made and they note the recommendations made to date and the actions in hand to address them.

2. Risk

ARC received detailed risk updates which highlighted the committee's key focus areas within risk, including agreed Risk KPIs, risk register review status, operational risks, on-going actions, risk resource and material risks.

There are currently no Operational Risk Registers overdue for review, with 43 of the 44 registers in date. The remaining one register is due within one month.

The current Material Risk Register was reviewed and of the 20 current material risks, 19 have been reviewed in detail with the Executive Responsible, in line with the agreed schedule. One new risk was proposed as material relating to the impact of increased

energy costs, one material risk has seen a reduction in its residual risk score, and three risks have seen an increase in their risk score.

The Committee also reviewed and subsequently approved the Principle Risks and Risk Management Statement to be reported within the Charity's Annual Report for 2021/22, subject to confirmation that the risk of excess assets be added to the Strategic Asset Principle Risk, and that the section relating to Board responsibility is amended to clarify the roles of both Board and the ARC. The Committee noted the positive comment from Grant Thornton over the thoroughness of this process and the level of debate and review afforded to the risks within the annual report.

3. Internal audit

The Committee reviewed the current internal audit update covering published reports, functional resource, audit actions dashboard and progress versus IA annual plan and following an update from the IARM, noted that there were 4 overdue actions (relating to two audits) at this point in time. These were all being addressed by the Responsible Executives in conjunction with the IARM. It was confirmed at the meeting that one action was now closed.

Four Internal Audit reports were published since the last meeting, with two rated as "Limited" and two as "Partial" assurance. The Committee were assured that the actions to address the Limited Audits were in hand under review, with follow-ups planned to review the implementation and embedding of the actions. The Committee were pleased to see that all audit reports relating to the remaining 2021/22 audit assignments have now been published.

The Committee noted concerns over the strength and effectiveness of the First Line of Defence within the Charity and how this was partly the cause of the limited audits and overall assurance rating.

The Committee is pleased that IA delivered the internal audit 2021/22 programme in full considering very limited resources available to the function and competing priorities. The Committee thanked Charity's staff and management for cooperative and open to learning approach when working with internal auditors.

The Committee also noted the progress with the 2022/23 IA Annual Plan, with two audits from the plan also concluded, with reports published. Both were advisory engagements, and assurance ratings were not provided on this occasion.

The Committee agreed that the previously approved option to have co-sourced audits within the current plan would be deferred and reconsidered within the 2023/24 financial budget and IA Annual Plan.

4. Counter fraud

The Committee received and reviewed the latest counter fraud activity update that included information on local proactive counter-fraud work, referrals for potential fraudulent activity in the previous period and wider horizon scanning for issues that may impact the Charity. The LCFS confirmed that the risk of fraud within the Charity remained low, however there would be further monitoring in conjunction with other LCFS' on the impact of the cost of living crisis and if this was increasing the likelihood for fraudulent activity. The Committee was satisfied with Local Counter Fraud Specialist work.

The Committee also received the Counter Fraud Annual Report and details of the 2021/22 NHSCFA Submission, (Appendix 02), which highlighted that the Charity was compliant with all standards. The Committee acknowledged the excellent work being done within Counter Fraud, and the string links being maintained by the LCFS with the NHSCFA.

5. Information Technology

The Committee received and noted the Caldicott Guardian & Senior Information Risk Owner Annual Report for 2021-22 (Appendix 03). Discussions focussed on the increase in Subject Access Requests and how best the Charity can facilitate these and the learnings required to improve the effectiveness and timeliness of the process. The Committee noted the good progress in this area.

The committee also received the latest IT and Cyber Security update that covered the on-going work relating to service performance, a status report on network improvement projects, the current key IT Risks and a review of current IT Security Metrics. Discussions were focussed on the impact of the Allocate project on the wider IT team and how some of the business as usual and Business Intelligence work has been delayed.

6. Board Assurance Framework

The Committee received an update on the new format of the Charity's BAF, ahead of July Board. The committee agreed that the BAF is making good progress and acknowledged that the further work required on control/assurance gaps and corresponding actions will be forthcoming at the next ARC and future Boards. The Committee reiterated it was important that the ARC focussed on the effectiveness of the BAF format and process and left the details over how the risks were being managed to the Board Committees and the Board itself.

7. Emergency Preparedness, Resilience and Response (EPRR)

The Committee received an update on further changes to the submission process for the Charity's EPRR response to NHSE. The review and oversight process, along with the timeline for review and submission has changed again this year and the committee noted that the EPRR submission would be presented to NHSE for review ahead of submitting to ARC and then on to Board. It was also noted that the standards for reporting this year had yet to be confirmed and released.

8. ARC Related Policies and Procedures review

ARC received an assurance paper on the Policies and Procedures relating to areas of oversight (either directly or indirectly) of the committee. Whilst the committee was assured that this suite of policies are being maintained effectively; remain relevant; appropriate; fit for purpose and within their agreed publication and review timeframes, further work is required to review Charity Commission general recommendations and ensure that StAH set of policies is in line with the best practices.

9. Annual Gifts and Hospitality Register review

ARC noted and approved the review, recognising the low level of registrations in this area and was satisfied with the system in place for declaring, reviewing, approving and reporting.

# Decisions made by the Committee:

- Approved the principle risks and risk statement for inclusion in the 2021/22 Annual Report – subject to the agreed changes

- Agreed that the previously approved option to have co-sourced audits within the current plan would be deferred and reconsidered within the 2023/24 financial budget and IA Annual Plan.
- Approved the IA Annual Report and Head of Audits Assurance Opinion
- Approved the Counter Fraud Annual Report

## Implications for the Charity Risk Register or Board Assurance Framework:

The Charity's Principle Risks and Risk Statements were approved ahead of inclusion into the 2021/22 Annual Report.

The ARC endorsed the proposed change to the Strategic Risk relating to "Strategic Assets and Estates Management", whereupon it would be amended to state "Strategic Asset Management" and have a wider risk remit to account for all Strategic Assets, along with ensuring the risk of excessive assets was considered within the "right sized" terminology within the risk description. The revised description is proposed as follows:

"Failure to acquire and maintain "right-sized" and "fit for purpose" strategic assets; coupled with ineffective management of the estate and IT infrastructure will result in, (i) The inability to expand on the strategic aim relating to provision and fulfilment of community based beds, (ii) Higher cost of maintenance impacting financial sustainability. (iii) Potential breach of regulations, and (IV) Reputational damage. All of which collectively will impede the Charity in achieving its strategic objectives."

The Committee also confirmed that further consideration should be given to the oversight of this risk and whether it should be split in future with a specific strategic risk for IT related assets.

## Issues/Items for referral to other Committees:

- Committee Chairs are requested to ensure that future discussions on Strategic Risks and oversight of their allocated areas within the BAF are scheduled early on in meeting agendas, so that the discussions can be prioritised and afforded the correct amount of discussion time.

## Issues Escalated to the Board of Directors for Decision:

- Board to ratify the proposed change in Strategic Risk relating to Strategic Asset Management.

## Appendices:

- Appendix 1 – Counter Fraud Annual Report (2021/22)
- Appendix 2 – Caldicott Guardian & SIRO Annual Report (2021/22)

# Committee Update Report to the Board of Directors

## Name of Committee:

Meeting of Directors of St Andrew's Pension Trustees Limited

## Date of Meeting:

7 July 2022

## Chair of Meeting:

Martin Kersey

## Significant Risks/Issues for Escalation:

- None

## Key issues/matters discussed:

- Initial Actuarial Valuation results and long-term objectives
- Review of Investment Committee Meeting of 29 May and Blackrock Q1 performance
- Inflation hedging accuracy
- Visited the Administration team
- Reviewed the annual planner and fee budget progression
- Reviewed an updated Internal Dispute Resolution Process and Register of Interests
- Late payment of part of the annual contributions by the Charity

## Decisions made by the Committee:

- Approved refreshing the Scheme's cashflows to improve the hedging accuracy.
- Approved the appointment of Martin Kersey and Rupert Perry to the Investment Committee
- Approval of updated Internal Dispute Resolution Process and Register of Interests
- Approval that the late payment of part of the annual contributions was not a reportable event to the Pensions Regulator.

## Implications for the Charity Risk Register or Board Assurance Framework:

- No change for Pension Risk on the Risk Register

## Issues/Items for referral to other Committees:

- None

## Issues Escalated to the Board of Directors for Decision:

- None

# Paper for Board of Directors

| | |
|---|---|
| **Topic** | Governance Oversight Group Update |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **8** |
| **Author** | Mel Duncan |
| **Responsible Executive** | John Clarke |
| **Discussed at Previous Board Meeting** | Last update given to Board in March 2022. |
| **Patient and Carer Involvement** | There has been no involvement with patients or carers for this item thus far. |
| **Staff Involvement** | Regular updates given by Project Manager to the Oversight Group and to the Project Sponsor. SMEs have also been consulted. |
| **Report Purpose** | Review and comment ☐<br>Information ☐<br>Decision or Approval ☐<br>Assurance ☒ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒ |
| **Strategic Priority Area** | Education and Training ☐<br>Finance & Sustainability ☐<br>Service Innovation ☐<br>Quality ☒<br>Research & Innovation ☐<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☐ |
| **Committee meetings where this item has been considered** | |

**Report Summary and Key Points to Note**

This update provides background, current work being undertaken and next steps for the charity's Governance Review Project to date, and is in addition to the regular updates given to the oversight group by the Project Manager.

**Appendices -**

St Andrew's HEALTHCARE

# Governance & Risk Review Project Update

John Clarke & Mel Duncan



Transforming lives together

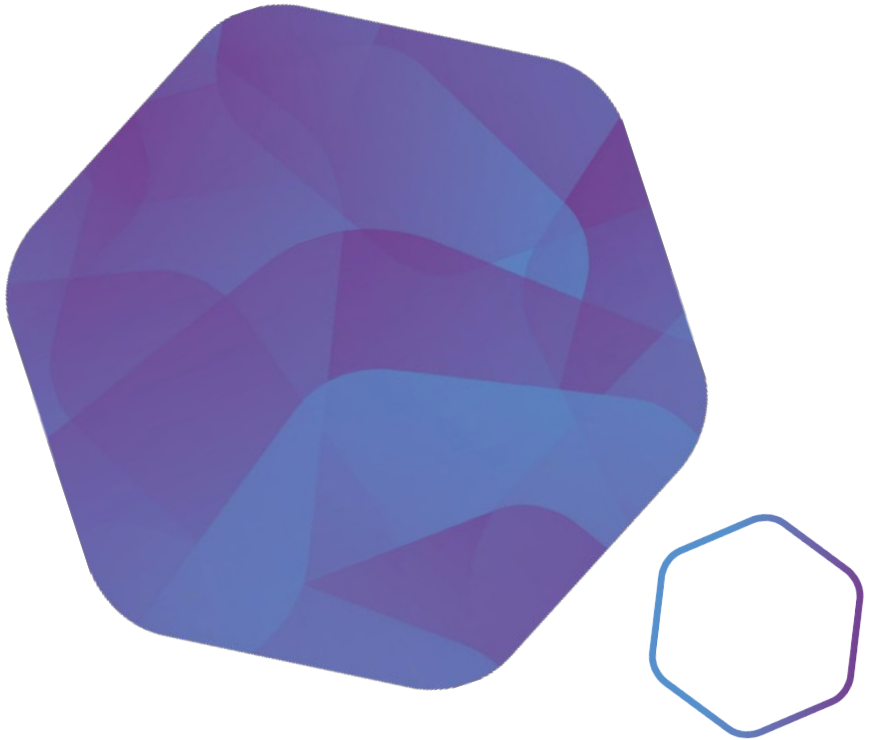
1 Background

2 Review Results & Timeline

3 Progress

4 Project Risks

5 Questions





St Andrew's HEALTHCARE

# Background

# Background




Full governance and risk review commissioned by St Andrews from Ernst & Young (E&Y)


E&Y review phase involving document review, meeting review and meetings with senior management and Board.


E&Y report published and shared with the Board and senior management. Project approved and initiated


Project kick-off and formation of Governance Oversight Group



St Andrew's HEALTHCARE

# Review
# Results & Timeline

# Review Results

## Governors

Role and effectiveness of Governors

## Board

Effectiveness, structure, assurance and underpinning frameworks

## Risk

Structure, landscape and appetite




St Andrew's HEALTHCARE

# Project Timeline



**Oct 2021 – Feb 2022**

- Project was initiated and structure formed. Baselines were noted and work had begun on developing the timeline.
- Expected project lifetime was 18 – 24 months.

**Mar 2022 – Apr 2022**

- Change of structure, due to resignation of previous PM.
- Formalised timeline was produced for approval along with PID.

**Apr 2022 to present**

- Project logistics
- Assessment of structure
- Board Improvement
- Risk management
- Risk appetite statement and methodology
- Project Pegasus

**The next 12 months**

- Sign off new structure, ToRs and governance templates
- Code of Conduct adoption
- Risk element phase 2
- Embedding
- Monitoring

# The next 12 months


- Finalise Authority Matrix
- Finalise Matters Reserved
- Prepare Terms of Reference for consideration by Committees and Board
- Overlay project plan with action from Well-Led audit


- Develop Terms of Reference for Court of Governors
- Develop Code of Conduct for Court of Governors
- Sign off new structure
- Agree Admin structure


- Embedding Phase
- Final phase of Risk elements
- Monitoring of governance principles
- Develop forward plan of review of landscape


- Begin Internal Audit of Governance landscape
- Product Governance Handbook
- Project becomes BAU
- Board to sign off project and handbook



St Andrew's HEALTHCARE

# Progress

# Progress so far

Project progress this far has been slow, this is due to a variety of factors, however, the largest has been resourcing.

## Governors

***Done***

- Appointment of a Lead Governor
- Governor visit programme
- Governor safety awareness training

***To Do***

- Development of a Code of Conduct
- Development of Terms of Reference

## Board & Committees

***Done***

- Committee duties
- Lines of reporting and assurance
- Meeting templates
- Board development sessions with NHSP

***To Do***

- Finalise Terms of Reference
- Development of Code of conduct
- Senior Independent Director role description
- Meeting Admin structure
- Further development of Authority Matrix and delegated authorities
- Assess Articles

## Risk

***Done***

- Risk Strategy
- Charity risk appetite and methodology
- Risk thresholds
- Risk register review
- Project Pegasus
- Policy and procedure review

***To Do***

- Phase 2 – monitoring
- Phase 3 – review

# Project Risks

# Project Risks



| Risk Title | Brief Risk Description | Initial Risk Ratings | | | Existing Controls | CurrentRisk Ratings | | |
|---|---|---|---|---|---|---|---|---|
| | | Impact | Likelihood | Risk Rating | | Impact | Likelihood | Risk Rating |
| Project Design | The project design may not be well defined or incomplete resulting in poor effectiveness and potential project failure | Moderate | Possible | High | Development of Project Initiation Document outlining full scope of project taking into account E&Y review. | Minor | Unlikely | Medium |
| Priorities | Lack of control of staff or charity priorities or unanticipated events may lead to project disruption and delay | Moderate | Possible | High | Clear communication with GOG and key stakeholders in order to mitigate any potential adverse occurances | Major | Possible | High |
| Communication | Lack of effective communication and oversight could result in lack of confidence in the project by the Board and the Charity | Moderate | Possible | High | Regular project reporting and 1:1 meetings with key stakeholders. Regular GOG meetings | Minor | Unlikely | Medium |
| Dependencies | Key person dependencies being compromised may lead to project slippage | Moderate | Possible | High | 1:1 meetings and GOG meetings in order to provide forum for discussion and mitigation if necessary | Minor | Possible | Medium |
| Resourcing | Insufficient resources and bandwith could result in poor delivery of objectives and project slippage | Major | Possible | High | Regular communication with HR and Recruitment in order to ensure back-fill is in place. | Major | Likely | Extreme |
| Sustainability | Failure to adopt the framework and sustain the principles across the Charity | Moderate | Possible | High | Embedding and monitoring phase of project will utilise effectiveness review and internal audit to ascertain progress | Minor | Possible | Medium |
| Timeline | Additional and unprecedented risks being identified thereby adversely affecting the length of the project | Moderate | Possible | High | No control in place | Major | Possible | High |

7 risks were initially identified for the project, with all of them rating as high. Over time, the extreme status of the resourcing risk has been noted with staffing challenges. These challenges remain until the start date of the new back-fill position which has been offered and accepted.

St Andrew's HEALTHCARE

# Questions



Transforming lives together

# Paper for Board of Directors

| | |
|---|---|
| **Topic** | CQC Report and Action – Progress Update |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **9** |
| **Author** | Jenny Kirkland |
| **Responsible Executive** | Andy Brogan |
| **Discussed at Previous Board Meeting** | Progress against CQC actions on the Quality Improvement Plan were discussed at the Board meeting on 22 May 2022. |
| **Patient and Carer Involvement** | Co-production activity across all three divisions has attributed to the closure of a number of actions within this reporting period. |
| **Staff Involvement** | Staff engagement and collaboration has been instrumental in the initiation and embedding of Quality Improvements across divisions. |
| **Report Purpose** | Review and comment ☐<br>Information ☐<br>Decision or Approval ☐<br>Assurance ☒ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☒ |
| **Strategic Priority Area** | Education and Training ☐<br>Finance & Sustainability ☐<br>Service Innovation ☐<br>Quality ☒<br>Research & Innovation ☐<br>Workforce, Resilience & Agility ☐<br>Partnerships & Promotion ☐ |
| **Committee meetings where this item has been considered** | Updates have been discussed at the Charity Executive Committee meetings and weekly Quality Improvement meetings. |

**Report Summary and Key Points to Note**

The attached is the report to the Board regarding the actions being taken following the CQC inspection of Women's and Men's services at Northampton.

The Quality Improvement Plan (QIP) continues to be monitored on a weekly basis, with input from all divisions and support functions.

54 CQC related QIP actions have been closed through the assurance process.

33 CQC related QIP actions are going through final assurance processes. 13 further CQC related QIP actions are currently in progress, with improvements being embedded across the divisions. Focus remains on collating sufficient evidence to move these through closure.

The East Midlands Alliance Quality Support Programme led by NHFT continues to support the Charity with the wider improvements identified, and these have been informed and linked to the actions identified in the QIP.

**Appendices -**

# CQC Report and Actions – Progress Update

**ALERT:**

The CQC re-inspected the Women's service in April and the Men's service and the Essex site in June. We are still waiting for the draft reports of these and have been advised, that due to internal CQC issues, to expect a delay in the reports for the Women's service and for Essex. The Men's report is expected to be received within the usual timeframe.

The actions following the inspections of Men's and Women's services in summer 2021 have been monitored by the weekly Quality Improvement Plan (QIP) meeting. There are 10 related actions that are currently open as a specific result of the inspections. A further 39 actions that have been completed are going through the agreed assurance process before closure is confirmed

**ADVISE:**

The quarterly divisional Integrated Quality and Performance reviews continue, enabling a collective review of a range of indicators, combined with clinical judgement and oversight of actions on the Charity wide QIP attributable to the relevant division and the Divisional QIP. This is triangulated with staffing data and financial performance.

The following table gives a breakdown of the number of actions aligned to the relevant CQC regulations by division and current progress state.

| | | LSSR | | | LD/ASD | | | Med Sec | | | Charitywide | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Closed | Completed awaiting closure | In progress | Closed | Completed awaiting closure | In progress | Closed | Completed awaiting closure | In progress | Closed | Completed awaiting closure | In progress |
| Regulation 10 | Dignity and Respect | 3 | | | | | | 3 | | | 2 | | |
| Regulation 12 | Safe Care and Treatment | 27 | 1 | | 4 | 12 | | 1 | 4 | 6 | 1 | | |
| Regulation 13 | Safeguarding service users from abuse and improper treatment | 1 | | | 1 | | | 1 | | | 1 | | |
| Regulation 16 | Receiving and acting on complaints | | | | | 1 | | | | | | | |
| Regulation 17 | Good governance | 4 | 1 | 1 | 1 | 2 | | | 1 | 1 | | | 3 |
| Regulation 18 | Staffing | | 2 | | 2 | 1 | | | 3 | | | | 2 |
| Regulation 9 | Person centred care | 2 | | | | 5 | | | | | | | |

The East Midlands Health Alliance Quality Improvement Programme, led by our 'buddy trust' Northampton Healthcare Foundation Trust, continues to support the broader improvement work for the Charity that has been identified.

Delays continue to be experienced with collating and presenting meaningful data, especially in regards to compliance, which is being met by extensive manual work-around. The delays in automating these processes, due to capacity issues within the information team, continue to have a direct impact on the ability to roll the quality improvements agreed across the whole Charity, as time is spent on assessing compliance rather than the quality of service delivered. We continue to provide the requested information to our external partners, including CQC and commissioners within the required timeframes.

On receipt of the CQC inspection reports a review of the current QIP and assurance processes will be undertaken and the relevant ward, division and Charity QIPs updated accordingly.

**ASSURE:**

The quarterly divisional Integrated Quality and Performance reviews continue, enabling a collective review of a range of leading and lagging indicators, combined with clinical judgement and oversight of actions on the Charity wide QIP attributable to the relevant division and the Divisional QIP. This is triangulated with staffing data and financial performance.

The regular QIP meetings are well attended and include representation from all divisions and support functions.

54 CQC related actions from the QIP have been completed and closed, with 33 actions having been completed, which are going through the assurance process, 13 actions remain in progress.

To provide a level of assurance to the CQC a weekly meeting was being held with the CQC, attended by the Director of Nursing for Quality, Jenny Kirkland, however, these have been stood down following discussions with the CQC and informal feedback from the inspectors that the actions highlighted in their reports last year have been addressed.

# Paper for Board of Directors

| | |
|---|---|
| **Topic** | Safer Staffing Report |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **10** |
| **Author** | Chloe Annan – Safer Staffing Matron |
| **Responsible Executive** | Andy Brogan, Chief Nurse |
| **Discussed at Previous Board Meeting** | Yes – May 2022 |
| **Patient and Carer Involvement** | Aspects of Safer Staffing have been discussed with patients, where appropriate to do so, within community meetings on the ward. |
| **Staff Involvement** | Staff across all divisions are regularly engaged with in order to review Safer Staffing levels on wards and ensure we are having the right clinical conversations. Divisions have helped provide the narrative in the report. |
| **Report Purpose** | Review and comment ☐<br>Information ☒<br>Decision or Approval ☐<br>Assurance ☒ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐ |
| **Strategic Priority Area** | Education and Training ☐<br>Finance & Sustainability ☐<br>Service Innovation ☐<br>Quality ☒<br>Research & Innovation ☐<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☐ |
| **Committee meetings where this item has been considered** | |

**Report Summary and Key Points to Note**

This report provides the Board with an overview of safer staffing across the Charity, in line with the requirements of the National Quality Board and the Developing Workforce Safeguards.

Safer staffing levels and skill mix are an essential element of providing safe and high quality care for our patients. It is therefore important that the Board has oversight of our staffing, alongside the rationale for any changes to base establishments, in order to assure itself that our wards have sufficient staff to operate safely. Demonstrating sufficient staffing is one of the essential standards that all healthcare providers must meet in order to also be compliant with CQC requirements.

**Assurance:**

Staff continue to refer to our Safer Staffing Policy and Procedure, which includes a concise staffing escalation plan and action cards should there be challenges. Each division also has a Qualified Contingency Plan, which is regularly reviewed and updated to ensure it accounts for any changes in clinical acuity across the wards. These plans have helped guide night site co-ordinators in their decision making, and helped to mitigate risk associated with insufficient qualified resource.

We have also recently reviewed our flex management process, which is the process by which wards may flex up or down above their baseline number, to account for temporary/short term changes in their acuity, occupancy and enhanced support levels. This hadn't been working as efficiently or flexibly as we had liked, and therefore a new refined process was agreed in June which places increased accountability on the divisional Triumvirate to maintain oversight and be sure of clinical justification in each case. The Safer Staffing Matron has also met with each divisional triumvirate and NM's (including Birmingham and Essex) to ensure consistent understanding of our Safer Staffing Approach, of which the MHOST evidence based tool is just a small part of it. The feedback from each of these sessions was positive. We have seen immediate increased responsiveness to flex reviews, as well as an improved understanding in flexible shift times to meet changing patient acuity and demand.

Establishment reviews are currently being completed and led by the Heads of Nursing, as per our planned 6 monthly review in June. However, it has been agreed that a charity wide set of MHOST data collection will not be completed, due the risk of this data being inaccurate (both overscoring and underscoring). We currently don't have a high enough proportion of our senior leaders having completed the MHOST acuity training, and therefore the focus for this review will be on clinical discussion, professional judgement and a review of quality/safety data.

We continue to have some inconsistencies and inefficiencies with our rostering and scheduling, which is causing an increased reliance on Workchoice or agency where not always required. Operations are working closely with divisional leads and Workchoice leads, through weekly staffing assurance meetings, to review and amend scheduling where required. The roll out of Allocate will help with this, however a significant shift in culture, behaviour and practices is still required for this to be fully effective.

The Board is asked to:

- Review the position of our safer staffing in line with the requirement to publish staffing data.
- Review and acknowledge the increased workforce risks and support the mitigating actions identified throughout.
- Note the work undertaken to date and ongoing work to develop an evidenced approach to decision making, and to ensure compliance with the Developing Workforce Safeguards recommendations.

**Appendices -**

# Safer Staffing Report

**Executive Summary**

The purpose of this report is to provide assurance on the current position across all sites and wards, in accordance with the National Quality Board (NQB) guidance and the Developing Workforce Safeguards. This report focuses on reporting both Safety and Quality data, and staffing fill rate data for all wards against the Charity's agreed Safer Staffing levels for the period of April to June 2022.

We continue to experience some challenges with our staffing levels, due to a number of factors; including but not limited to, Covid absences, high absences rates overall, numbers of no shows and the current establishment gap. The report describes how the Charity responded to mitigate some of these shortages, where these occurred. The report provides the board with assurance on how safer staffing is being managed across the Charity.

1. **Background**

   As part of the NHS England 'Hard Truths' minimum standards NHS trusts are required to present a monthly update report to the Public Trust Board containing a summary of planned and actual staffing on each ward; and this is a gold standard St Andrew's will now follow.

   Organisations are expected to monitor their compliance with the NQB recommended 'triangulated approach' to staffing decisions, which combines the use of evidence-based tools, professional judgement and outcomes, to ensure the right staff with the right skills are in the right place at the right time considering patients' needs, acuity, dependency and risks.

2. **Safe Staffing Daily Oversight and Monitoring**

   The Clinical Ops Hub continues to be a vital source of managing safer staffing on a day to day basis. Our recently appointed Clinical Ops Hub Manager and Senior Manager on Site (SMoS) continue to work closely with the allocated divisional bleep holders to record, action and monitor safer staffing across the site. Safer staffing discussions are now based around the 'feel of the ward', clinical acuity of the patients and skill mix of staff, rather than numbers alone.

   A daily site meeting call takes place, led by the SMoS, with representatives from all divisions. This forum provides the opportunity for all issues related to safer staffing to be raised, escalated and discussed. For wards where staffing concerns are escalated, the SMoS maintains oversight of the site as a whole and reviews the ability to redeploy between divisions. Where staffing concerns cannot be mitigated, actions cards may be implemented, guiding wards on the actions to take.

   <u>Safer Staffing Approach</u>

   Throughout the month of June, the Safer Staffing Matron held face to face sessions with divisional Triumvirates and Nurse Managers for all divisions, including Birmingham and Essex. Following the role out of the MHOST tool in January 2022 and a new flexible safer staffing approach, these sessions were to ensure there is a continued consistent understanding and approach to:

   1. The use of the MHOST model as part of our safer staffing approach; what it is for each division and how occupancy and acuity may impact this.
   2. The emphasis of our daily staffing discussions needing to be more around clinical acuity and skill mix, and less around a single number assuring us of safety on a ward.
   3. How these numbers may be flexed temporarily with oversight and agreement needed by each Triumvirate
   4. How flexed numbers will be reviewed and returned/extended.

New Flex Management process

1. Flex review forms sent out to each division every Monday– which will detail all of the current temporary flex (broken down at ward level). Heads of division/Clinical Directors to provide clinical justification for each flex for each ward, along with financial implications and considerations.
2. This form is then submitted back to the Safer Staffing Matron by Tuesday.
3. Any temporary flexes that are approved will be for a period of 7 days. Following which a review must be completed if this is to be extended.

Establishment reviews

NQB's Workforce Safeguards guidance states that providers:

1. Should have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times
2. Must use an approach that reflects current legislation and guidance where it is available.
3. Must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.

MHOST (Mental Health Optimum Staffing tool) is just part of our overall Safer Staffing picture, and on its own will not solve our current staffing challenges. The MHOST tool itself provides us with a systematic approach, and one that is evidence based. However, how we deploy staff, our skill mix, and determining our day to day safe working will not be solved with MHOST. We have a significant way to go in terms of changing our culture, behaviours and ways of working to support us in implementing Safer Staffing, and this requires flexibility and openness to new ways of working. Our ability to deploy effectively across our wards, is heavily dependent on our ability to hold the right clinical discussions that are patient centred and based on acuity, and not numbers led.

An establishment review for all wards, as per our agreed process was due in June 2022 this year. Due to the MHOST acuity training still being rolled out, and not a high enough proportion of our senior leaders having yet completed it, it was agreed that a charity wide data collection would not be completed. This is due to the likeliness of wards both over and under scoring when using the MHOST descriptors without training, which could ultimately cause inaccuracies with the data collected. Instead, we have agreed to continue with the reviews with a triangulation of; clinical discussion, professional judgement and quality/safety data. Heads of Nursing within each division are taking the lead on this and will consider the following as a minimum; enhanced support levels and occupancy over the last 3 months (as well as projected), quality and safety data including incident levels and any significant change in service provision or patient group that has occurred recently. Ward clinical teams, including the NM's of each ward, will be fully involved in these discussions and final agreed establishment figure.

3. **Staffing Fill Rates for April, May and June 2022**

Below are the staffing fill rates for the last 3 months, showing our variance on each ward for qualified and unqualified staff against our planned number position. There are several wards that were above their planned position, and this is largely due to our temporary flex uplift process. Wards may be approved temporary flex uplifts if they have significant changes to patient acuity, occupancy or levels of enhanced support, which are not manageable within their planned number.

For the Northampton site, qualified fill rate in the day will be minimally impacted by the running of the Clinical Operations Hub – for which CNLs that hold the bleep (mostly in the afternoon and weekends) – are coded out of numbers to be able to fulfil this role efficiently. This has not been built into wards qualified base establishment, as ward level impact is minimal due to being shared out between the wards. In the short term, the presence of the CNL on site and their ability to be visible across all of the wards within the division, helps mitigate some of the risk relating to qualified fill rate and skill mix.

In the longer term, the Charity is recruiting additional Site Co-ordinators, and interviews commenced for these in July. They will be based in the Clinical Ops Hub and take over this day to day role from our CNLs and NMs, allowing them to focus on providing direct patient care. The recruitment of the Clinical Site Co-ordinators will also mean we will have a smaller, core group of people that will be trained and up skilled in safer staffing discussions. This will provide additional assurance that we are deploying staff based on clinical acuity, and that we have the right staff with the right skills, in the right place at the right time.

## Fill Rates & Divisional Risk Summary:

### ASD/LD:

April:

| | Day | | Night | | |
|---|---|---|---|---|---|
| Directorate | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **ASD & LD** | **100.8%** | **101.0%** | **95.0%** | **103.7%** | **92.6%** |
| ASD Acorn | 69.2% | 86.8% | 102.4% | 85.5% | 100.0% |
| ASD Berry | 79.7% | 137.4% | 106.8% | 100.0% | 96.3% |
| ASD Brook | 111.8% | 89.5% | 102.0% | 94.1% | 102.2% |
| ASD Fern | 92.9% | 101.8% | 101.0% | 123.4% | 111.1% |
| ASD Garden Cottage | 98.5% | 97.8% | 84.1% | 69.8% | 120.0% |
| ASD Marsh | 109.4% | 107.1% | 106.9% | 122.9% | 67.5% |
| ASD Meadow | 100.2% | 103.5% | 99.1% | 80.4% | 88.3% |
| ASD Sycamore | 137.7% | 85.5% | 105.2% | 102.8% | 100.0% |
| LDD Church | 112.4% | 113.4% | 104.2% | 107.2% | 86.7% |
| LDD Hawkins | 89.4% | 79.8% | 75.4% | 144.5% | 78.7% |
| LDD Oak | 78.8% | 122.8% | 76.4% | 113.2% | 90.0% |
| LDD Sunley | 124.2% | 82.3% | 111.0% | 90.1% | 92.9% |
| MMH Wantage Cottage | | 109.4% | | 102.1% | 100.0% |
| **Total** | **100.8%** | **101.0%** | **95.0%** | **103.7%** | **92.6%** |

May

| | Day | | Night | | |
|---|---|---|---|---|---|
| Directorate | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **ASD & LD** | **102.2%** | **100.7%** | **102.5%** | **106.0%** | **89.2%** |
| ASD Acorn | 61.4% | 73.7% | 100.9% | 59.9% | 106.8% |
| ASD Berry | 90.1% | 124.5% | 112.5% | 94.1% | 100.0% |
| ASD Brook | 100.2% | 97.7% | 105.1% | 99.0% | 90.0% |
| ASD Fern | 92.2% | 94.9% | 105.8% | 131.2% | 100.0% |
| ASD Garden Cottage | 93.3% | 95.3% | 103.0% | 68.4% | 100.0% |
| ASD Marsh | 95.1% | 138.1% | 127.2% | 152.2% | 77.1% |
| ASD Meadow | 91.6% | 91.9% | 99.9% | 82.8% | 82.3% |
| ASD Sycamore | 168.2% | 79.9% | 95.8% | 104.0% | 100.0% |
| LDD Church | 109.4% | 103.4% | 118.1% | 105.4% | 70.0% |
| LDD Hawkins | 101.4% | 98.9% | 84.3% | 158.2% | 71.4% |
| LDD Oak | 83.7% | 124.0% | 89.4% | 120.8% | 100.0% |
| LDD Sunley | 156.1% | 79.3% | 112.7% | 100.3% | 93.3% |
| MMH Wantage Cottage | | 98.2% | | 100.8% | 100.0% |
| **Total** | **102.2%** | **100.7%** | **102.5%** | **106.0%** | **89.2%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **ASD & LD** | **108.4%** | **101.9%** | **96.7%** | **106.1%** | **91.2%** |
| ASD Acorn | 60.9% | 67.8% | 101.9% | 61.4% | 90.0% |
| ASD Berry | 96.0% | 121.9% | 97.6% | 96.7% | 100.0% |
| ASD Brook | 114.1% | 93.2% | 101.9% | 99.4% | 100.0% |
| ASD Fern | 108.3% | 102.9% | 100.0% | 139.0% | 111.1% |
| ASD Garden Cottage | 101.9% | 98.2% | 100.2% | 70.1% | 125.0% |
| ASD Marsh | 120.9% | 130.3% | 108.5% | 158.2% | 80.0% |
| ASD Meadow | 106.9% | 93.7% | 100.8% | 86.3% | 90.0% |
| ASD Sycamore | 162.5% | 80.9% | 100.1% | 106.9% | 100.0% |
| LDD Church | 114.5% | 110.0% | 109.3% | 96.8% | 82.6% |
| LDD Hawkins | 109.7% | 93.9% | 74.9% | 155.6% | 71.4% |
| LDD Oak | 96.7% | 123.6% | 82.7% | 115.2% | 77.3% |
| LDD Sunley | 107.2% | 95.3% | 111.8% | 101.1% | 100.0% |
| MMH Wantage Cottage | | 108.0% | | 114.7% | 100.0% |
| **Total** | **108.4%** | **101.9%** | **96.7%** | **106.1%** | **91.2%** |

ASD/LD have had fairly stable total fill rates over the last 3 months, with the day totals for both Q and HCA being consistently above 100%. The slightly reduced night Q fill rate (being at 96.7% for the month of June), reflects a qualified establishment gap, as well as the need for occasional night Q redeployment to support other wards across the site. Hawkins and Oaks have consistently been the most effected wards by this, with both wards planned to have 2 qualifieds at night, and therefore often required to redeploy from. Although not hitting their Q planned position at night, there have been no action cards or specific concerns raised in relation to this gap.

Acorn have flexed down from their baseline number over the last 3 months, to reflect a reduction in their ward acuity and enhanced support levels since the baseline was completed in July 2021. This is in both HCA's and Qualified, with the planned number as 3 in the day, however often scheduling to 2. This flex down has been clinically manageable for the ward, and has allowed resource to be redeployed to other wards within the division that have seen an increase in their acuity and need.

The division has also been trialling a new role of 'Ward Operations Lead'. This role has been taking on the overall responsibility of scheduling and rostering for a number of complex wards within the division. This role has then subsequently given Nurse Managers and CNL's more time directly on the wards, working closely with both staff and patients.

ASD/LD haven't implemented any action cards over the last 3 months.

**Birmingham:**

April:

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Birmingham** | **102.9%** | **115.6%** | **95.2%** | **147.4%** | **104.1%** |
| MMH Edgbaston | 116.3% | 86.5% | 74.7% | 153.3% | 98.4% |
| MMH Hawkesley | 83.9% | 96.4% | 120.0% | 108.7% | 106.4% |
| MMH Lifford | 128.2% | 116.3% | 95.5% | 142.4% | 100.0% |
| MMH Moor Green | 99.6% | 137.8% | 106.9% | 191.7% | 100.0% |
| MMH Northfield (Old Lifford) | 72.1% | 151.4% | 93.8% | 141.8% | 106.7% |
| MMH Speedwell | 102.5% | 105.3% | 130.3% | 94.1% | 100.0% |
| WMH Hazelwell | 101.5% | 121.3% | 132.2% | 150.5% | 145.8% |
| WMH Hurst | 128.6% | 127.8% | 61.8% | 249.2% | 92.7% |
| **Total** | **102.9%** | **115.6%** | **95.2%** | **147.4%** | **104.1%** |

May:

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Birmingham** | **104.1%** | **117.3%** | **92.5%** | **141.5%** | **104.8%** |
| MMH Edgbaston | 123.3% | 94.4% | 64.8% | 183.7% | 100.0% |
| MMH Hawkesley | 89.0% | 112.1% | 128.7% | 88.5% | 106.5% |
| MMH Lifford | 128.2% | 141.6% | 114.2% | 149.6% | 99.8% |
| MMH Moor Green | 110.7% | 129.7% | 102.2% | 192.3% | 100.0% |
| MMH Northfield (Old Lifford) | 71.6% | 144.4% | 97.3% | 129.0% | 106.5% |
| MMH Speedwell | 97.1% | 101.4% | 119.7% | 98.0% | 100.0% |
| WMH Hazelwell | 109.3% | 106.7% | 104.6% | 148.9% | 165.4% |
| WMH Hurst | 111.3% | 129.5% | 64.3% | 214.2% | 89.1% |
| **Total** | **104.1%** | **117.3%** | **92.5%** | **141.5%** | **104.8%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Birmingham** | **107.9%** | **112.6%** | **94.4%** | **138.6%** | **104.4%** |
| MMH Edgbaston | 117.7% | 79.6% | 56.6% | 146.2% | 100.0% |
| MMH Hawkesley | 93.2% | 113.4% | 153.3% | 92.2% | 102.9% |
| MMH Lifford | 120.8% | 118.7% | 118.2% | 112.2% | 99.0% |
| MMH Moor Green | 114.3% | 128.4% | 104.3% | 195.2% | 100.0% |
| MMH Northfield (Old Lifford) | 95.0% | 122.1% | 100.1% | 130.6% | 104.9% |
| MMH Speedwell | 96.8% | 98.5% | 102.4% | 99.1% | 99.0% |
| WMH Hazelwell | 108.3% | 128.2% | 122.7% | 173.1% | 183.3% |
| WMH Hurst | 124.4% | 117.5% | 65.0% | 203.6% | 90.0% |
| **Total** | **107.9%** | **112.6%** | **94.4%** | **138.6%** | **104.4%** |

Total fill rates for the Birmingham site have sat at 100% or above for the last 3 months, with the exception of the night qualified fill rate (with June being at 94.4%). Both Edgbaston and Hurst have been most affected by this, with both wards planned to have 2 at night, however frequently needing to redeploy the 2nd to support qualified provision across the division. This has been partly mitigated by these wards being able to backfill with HCA's.

Birmingham haven't implemented any action cards over the last 3 months.

**CAMHS:**

April:

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **CAMHS** | **90.4%** | **153.9%** | **68.8%** | **195.6%** | **98.3%** |
| CAM Seacole Mixed Rehab | 92.0% | 88.7% | 65.9% | 103.7% | 95.6% |
| CAM Sitwell Boys MSU | 77.9% | 942.2% | 107.1% | 537.6% | 125.0% |
| CAM Stowe Mixed Admissons | 101.1% | 86.7% | 52.4% | 138.3% | 90.0% |
| **Total** | **90.4%** | **153.9%** | **68.8%** | **195.6%** | **98.3%** |

May:

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **CAMHS** | **78.8%** | **170.3%** | **64.5%** | **208.4%** | **90.3%** |
| CAM Seacole Mixed Rehab | 74.8% | 111.5% | 58.2% | 122.0% | 95.0% |
| CAM Sitwell Boys MSU | 84.9% | 880.1% | 98.8% | 539.7% | 119.4% |
| CAM Stowe Mixed Admissons | 76.5% | 103.2% | 53.6% | 163.8% | 74.5% |
| **Total** | **78.8%** | **170.3%** | **64.5%** | **208.4%** | **90.3%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **CAMHS** | **65.7%** | **170.1%** | **63.5%** | **177.8%** | **72.0%** |
| CAM Seacole Mixed Rehab | 68.4% | 104.8% | 51.7% | 109.7% | 70.7% |
| CAM Sitwell Boys MSU | 61.3% | 895.8% | 95.5% | 409.6% | 100.0% |
| CAM Stowe Mixed Admissons | 67.4% | 105.7% | 59.3% | 156.0% | 62.0% |
| **Total** | **65.7%** | **170.1%** | **63.5%** | **177.8%** | **72.0%** |

Billing Lodge isn't named specifically in the above fill rates due to the fact it is scheduled as part of Sitwell, however they still have separate planned numbers. This explains some of the significantly high HCA fill rates in Sitwell both day and night.

Total HCA fill rates for the division both day and night have been above 100% over the last 3 months. However, these don't reflect some of the continued staffing challenges CAMHS have had during this period. All of the CAMHS wards have been flexing up (increasing their staffing requirement above their planned number) for periods due to increased acuity and enhanced support levels. HCA fill rate is also increased due to the division being able to backfill some of their Q gaps, which has helped mitigate any risk associated with reduced qualified resource.

To summarise, the significantly high HCA fill rates across the CAMHS wards both day and night are due to the following reasons; Billing is scheduled into Sitwell despite being planned for separately; all of the wards have flexed up above their baseline number for periods of time throughout June due to increase in acuity and ES levels; and finally, the wards are mitigating the risk associated with their ongoing qualified gaps, by backfilling and increasing the proportion of HCA's. This then takes the ward above their HCA planned number, but still within their current ward requirement (as the qualified planned number hasn't been filled). A baseline establishment review of all wards across all divisions is currently be completed with view for new figures to be in place by the end of July.

CAMHS continue to have significant challenges with their qualified resource and availability, with fill rates progressively reducing from April to June, and been particularly impacted in June due to a number of new HR investigations. All of the wards are planned to have 2 qualifieds both day and night (with the exception of Sitwell at night), however they are regularly needing to redeploy the 2nd qualified to ensure adequate qualified provision across the division (1 on each ward). There have been numerous occasions throughout June where some wards have had no qualified scheduled in day and night, and they haven't been able to resolve this within the division. Therefore support has been requested and sought from other divisions on the site. This risk has also been somewhat mitigated by the presence of Nurse Managers, Head of Nursing and Quality Matron's on the wards, all of which are qualified nurses, however are not usually counted in the ward staffing number.

Although the division as a whole is at a reduced occupancy, the significant enhanced support levels and acuity of the remaining patients has been the main contributing factor for a rising staffing requirement. However, the division have been reviewing this weekly very closely with the

ward clinical teams and are regularly exploring alternative management plans. In June, the division discharged a couple of over 18 patients and have also been able to safely review and reduce ES levels where appropriate. The graph below shows the changing ES levels in CAMHS and clearly identifies the peak they experienced in May/June, and subsequent decrease in June since the commencement of weekly reviews.


As a result of some of their continued staffing challenges, the division have had to implement action cards on a number of occasions.

*1/04/22 – CAMHS – Shortage of Staff*
Implemented during a night shift due to the division being 14 below ward planned, and Seacole and Stowe feeling unmanageable. The escalation process was followed correctly and night site co-ordinators were unable to base themselves on wards. Clinical acuity was reviewed across all three wards and staff were redeployed to support the most clinically acute areas. This was felt to mitigate the risk for the shift

*2/04/22 – CAMHS – Shortage of Staff*
This action card was implemented during a day shift due to being below planned numbers and the wards feeling clinically unmanageable with their current resource. The division, along with the SMoS for that day, correctly followed the escalation procedure. Staff were redistributed within CAMHS to support the most clinically acute wards. Enhanced support on Sitwell was reduced at times throughout the day, however no clinical harm was reported as a result of this. All surrounding wards and divisions were made aware of the challenges within CAMHS and advised to respond immediately for any urgent requests for support/group alerts/medical emergencies.

*8/05/22 – CAMHS – No Qualified on shift & Shortage of Staff*
Two clinical action cards were implemented; one due to insufficient qualified staff, and the other for shortage of staff. Overall staffing levels on the three CAMHS wards were below planned for this shift, and although initially clinically manageable, this was escalated to the SMoS at 00:00 when twilights left the division. Due to the clinical acuity on Stowe and Seacole, the NIC on Sitwell had to leave the ward on several occasions to support the rest of the division. The correct escalation process was followed and CAMHS first reviewed their own deployment options. Bleep holder (who was also the NIC on Sitwell) contacted the other divisional bleep holders, however no support was identified initially. This was then escalated to the SMoS and a site wide meeting scheduled at 01:15, where four staff from other divisions were redeployed to help close the

action cards. No clinical harm was reported as a direct result of using this action card for this period of time.

*9/05/22 – CAMHS – Shortage of Staff*
An action card was implemented for the day shift due to a shortage of staff across the division, with all three wards being below planned numbers and a 'feel' of the wards being unsafe for patients and staff. This action card resulted in some temporary restrictive practices being implemented, including temporary zonal nursing and suspension of all non-essential patient care functions and non-essential patient leave. This was required to help mitigate the risk and help ensure a level of observation for all patients. The division was also unable to temporarily cover LTS enhanced observations for a patient that is over 18. This patient is usually nursed off ward due to age, however had to be nursed on the ward with the other patients for a period of time. A safeguarding concern was raised due to this and this, along with the staffing concern, was escalated as per our escalation and action card process. MDT, enabling function, education and wider site support was requested to help close this action card.

*20/05/22 – CAMHS – Shortage of Staff*
Action card implemented due to a shortage of staff on Seacole ward in CAMHS that came into effect during the day shift from 4pm to 7.45pm. MDT and education staff had been supporting the division during the day and left at 4pm. Nursing staff across the division were redistributed to balance as much as possible based on clinical acuity and immediate needs. Response was not available from the CAMHS wards during this time, however surrounding wards and divisions were made of their need to respond to any group alerts or medical emergencies.

*27/05/22 – CAMHS – Shortage of Staff & No Q on shift*
This was implemented during the night shift and applied to the CAMHS division as a whole, due to a number of unfilled vacancies. There was unfilled Q vacancy on Seacole, and the night Q on Stowe also called in sick just before start of shift. Night site co-coordinator based themselves on Seacole to help mitigate this risk, and the scheduled night Q from Sitwell was redeployed to Stowe due to higher acuity. This then left Sitwell with no Q after midnight, for which the contingency plan was implemented and the medication keys left with the adjacent ward. In addition, a patient on Seacole who was on 3:1 had to be reduced to 1:1, although two other staff were allocated to respond if needed. No clinical harm was reported following this reduction in observation levels.

The CAMHS division does continue to have daily presence of education and therapy staff, which has helped to mitigate some of the risks associated with the reduced fill rates seen above. They are also very closely supported by our Quality Matrons, who have been working with both staff and patients to review quality of care and practices, and leading on a number of improvement initiatives. The division has also had daily senior nursing leadership visibility and input from the Nurse Managers and Heads of Nursing. A number of practice educators are also working with the nursing teams on the ward, with a specific focus around assessing and upskilling our qualified nurses.

**Essex:**

<u>April</u>

| | Day | | Night | | |
|---|---|---|---|---|---|
| Directorate | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Essex** | **80.3%** | **129.3%** | **77.6%** | **111.3%** | **102.3%** |
| MMH Audley | 57.2% | 206.4% | 78.7% | 109.2% | 71.9% |
| MMH Benfleet | 97.8% | 77.2% | 55.7% | 95.7% | 201.0% |
| MMH Danbury | 88.1% | 135.4% | 102.3% | 125.4% | 101.2% |
| WMH Colne | 74.5% | 149.3% | 82.4% | 143.8% | 81.7% |
| WMH Frinton | 66.9% | 216.1% | 67.8% | 114.2% | 87.0% |
| WMH Maldon | 153.8% | 75.0% | 104.8% | 73.7% | 120.0% |
| **Total** | **80.3%** | **129.3%** | **77.6%** | **111.3%** | **102.3%** |

May

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Essex** | **79.1%** | **114.0%** | **76.8%** | **109.9%** | **95.9%** |
| MMH Audley | 63.8% | 201.3% | 78.1% | 127.5% | 71.5% |
| MMH Benfleet | 98.9% | 79.1% | 52.6% | 97.7% | 143.7% |
| MMH Danbury | 105.7% | 108.3% | 107.8% | 116.5% | 119.4% |
| WMH Colne | 66.1% | 125.7% | 78.5% | 121.5% | 69.2% |
| WMH Frinton | 54.7% | 180.7% | 78.4% | 108.8% | 74.5% |
| WMH Maldon | 135.6% | 60.0% | 85.3% | 79.5% | 100.0% |
| **Total** | **79.1%** | **114.0%** | **76.8%** | **109.9%** | **95.9%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Essex** | **71.1%** | **112.8%** | **79.7%** | **120.0%** | **88.7%** |
| MMH Audley | 55.3% | 202.0% | 85.2% | 131.8% | 68.1% |
| MMH Benfleet | 87.6% | 68.4% | 57.8% | 95.1% | 111.9% |
| MMH Danbury | 82.9% | 112.9% | 105.2% | 124.8% | 110.2% |
| WMH Colne | 66.9% | 114.6% | 71.0% | 132.4% | 64.3% |
| WMH Frinton | 59.7% | 207.0% | 83.1% | 143.6% | 69.3% |
| WMH Maldon | 107.4% | 62.1% | 97.4% | 82.2% | 120.0% |
| **Total** | **71.1%** | **112.8%** | **79.7%** | **120.0%** | **88.7%** |

Total HCA fill rates both day and night have been above 100% in Essex over the last 3 months. These fill rates reflect; the divisions requirement to flex above baseline for periods due to increases in acuity, ES and occupancy; and also their ability to backfill some of their gaps in planned qualified numbers.

Essex continue to have some challenges with their total qualified fill rates both day and night, sitting at 80% or below consistently. The two PICU wards, Audley and Frinton are both planned to have 3 qualifieds in the day however haven't consistently reached this. This is due to a qualified establishment gap across the site, which has left a number of qualified needs unfilled. Also, the wards planned to have 2 or 3 are often redeployed to ensure adequate qualified provision across the site as a whole.

Benfleet however, have a reduced qualified fill rate at night due to clinically agreeing to temporarily flex down their requirement for qualified nurses at night from 2 to 1. This is due to a decrease in clinical acuity on the ward.

Essex have implemented 1 action card within the last 3 months.

*24/05/22 – Essex – No Q on shift*
This was implemented on Maldon ward for the first 1 hour of the night shift (8-9pm). This was discussed with the SMoS, and it was agreed that this was clinically manageable for the short period of time due to having 6 patients, all with low clinical acuity and an all regular HCA team on duty. A clear nursing escalation process was identified to staff on the ward, should qualified assistance have been required during this time. Action card ended when agency Q was sourced and arrived at 9pm, and no clinical harm was reported.

**Low Secure:**

April

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Low Secure & Specialist Rehab** | **83.3%** | **105.0%** | **73.8%** | **114.3%** | **92.7%** |
| FMH - 37 Berkeley Close | | 67.1% | | 64.6% | 100.0% |
| MMH Berkeley Lodge | 70.2% | 104.3% | 101.3% | 91.2% | 100.0% |
| MMH Heygate | 70.4% | 107.6% | 52.7% | 135.9% | 92.6% |
| MMH Spencer North | 96.2% | 88.3% | 92.7% | 97.4% | 100.0% |
| MMH Spencer South | 93.9% | 99.2% | 108.8% | 105.0% | 99.4% |
| WMH Bayley | 64.8% | 108.1% | 52.5% | 137.4% | 76.3% |
| WMH Naseby | 102.5% | 86.4% | 50.5% | 111.7% | 84.0% |
| WMH Silverstone | 83.6% | 194.5% | 86.9% | 185.0% | 90.0% |
| WMH Watkins House | 92.4% | 99.8% | 97.2% | 82.5% | 100.0% |
| **Total** | **83.3%** | **105.0%** | **73.8%** | **114.3%** | **92.7%** |

May

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Low Secure & Specialist Rehab** | **85.9%** | **101.8%** | **74.7%** | **121.3%** | **92.8%** |
| FMH - 37 Berkeley Close | | 63.4% | | 66.4% | 100.0% |
| MMH Berkeley Lodge | 67.5% | 104.8% | 100.9% | 90.1% | 100.0% |
| MMH Heygate | 82.6% | 109.7% | 53.0% | 156.8% | 90.0% |
| MMH Spencer North | 94.8% | 78.3% | 103.8% | 98.6% | 99.5% |
| MMH Spencer South | 102.3% | 96.9% | 108.7% | 110.1% | 89.2% |
| WMH Bayley | 70.3% | 99.9% | 50.8% | 147.6% | 87.8% |
| WMH Naseby | 100.3% | 75.9% | 50.2% | 121.7% | 88.3% |
| WMH Silverstone | 82.2% | 208.5% | 86.3% | 187.9% | 90.0% |
| WMH Watkins House | 94.6% | 95.0% | 102.6% | 92.3% | 100.0% |
| **Total** | **85.9%** | **101.8%** | **74.7%** | **121.3%** | **92.8%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Low Secure & Specialist Rehab** | **83.5%** | **110.9%** | **73.3%** | **131.1%** | **95.0%** |
| FMH - 37 Berkeley Close | | 64.3% | | 65.9% | 100.0% |
| MMH Berkeley Lodge | 72.2% | 118.9% | 100.7% | 97.1% | 100.0% |
| MMH Heygate | 76.9% | 158.8% | 54.0% | 214.3% | 98.5% |
| MMH Spencer North | 101.7% | 81.2% | 100.2% | 98.1% | 100.0% |
| MMH Spencer South | 85.7% | 96.0% | 104.9% | 104.3% | 96.4% |
| WMH Bayley | 80.9% | 100.3% | 52.6% | 135.9% | 95.9% |
| WMH Naseby | 86.8% | 86.3% | 51.2% | 125.8% | 90.9% |
| WMH Silverstone | 78.5% | 201.7% | 77.8% | 213.4% | 81.8% |
| WMH Watkins House | 92.1% | 102.1% | 102.6% | 105.9% | 100.0% |
| **Total** | **83.5%** | **110.9%** | **73.3%** | **131.1%** | **95.0%** |

Low secure have consistently had total HCA fill rates of 100% or above, over the last 3 months. Similarly to other divisions, this reflects their requirement to flex above their planned base number on some of the wards due to increased acuity and ES levels. As well as their ability to backfill some of their planned qualified gaps, helping to mitigate this risk.

37 Berkley Close and Naseby have both been flexing down from their base number day and night, due to a reduction in clinical acuity and ES levels, which has meant this has been clinically manageable. This has also then allowed resource to be temporarily redeployed to Heygate for example, that have seen increased staffing need at times due to rising occupancy and ES levels.

Silverstone also continue to flex up significantly from their base number day and night due to a number of clinical changes since the baseline establishment was agreed in July 2021.

The division continues to experience some challenges with their day and night qualified provision, and is an area where recruitment drives are continuing as well as regular reviews of base schedules and rostering. A number of the wards are planned to have 2 qualifieds at night, however over the last 3 months these wards have often had to support other wards within their division, or across the site to ensure adequate qualified provision. Despite this, the division has not implemented any action cards during this 3 month period.

**Medium Secure:**

<u>April:</u>

| | Day | | Night | | |
|---|---|---|---|---|---|
| Directorate | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Medium Secure** | **95.8%** | **95.3%** | **90.1%** | **99.7%** | **96.5%** |
| MMH 23a The Avenue | | 105.7% | | 100.0% | 66.7% |
| MMH Cranford | 70.8% | 139.7% | 98.5% | 118.5% | 102.1% |
| MMH Fairbairn | 105.1% | 88.2% | 100.0% | 97.0% | 101.7% |
| MMH Mackaness | 73.3% | 29.0% | 94.8% | 46.1% | 22.7% |
| MMH Prichard | 103.1% | 102.8% | 64.3% | 125.4% | 100.0% |
| MMH Robinson | 126.6% | 89.5% | 100.6% | 84.6% | 106.3% |
| NPS Rose | 131.7% | 101.0% | 123.5% | 112.2% | 97.9% |
| WMH Bracken | 86.7% | 102.3% | 60.8% | 96.5% | 95.0% |
| WMH Maple | 93.9% | 96.1% | 99.2% | 124.2% | 102.2% |
| WMH Willow | 89.9% | 109.8% | 112.4% | 97.0% | 101.4% |
| **Total** | **95.8%** | **95.3%** | **90.1%** | **99.7%** | **96.5%** |

<u>May</u>

| | Day | | Night | | |
|---|---|---|---|---|---|
| Directorate | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Medium Secure** | **96.6%** | **93.2%** | **94.4%** | **96.1%** | **97.4%** |
| MMH 23a The Avenue | | 101.1% | | 100.0% | 66.7% |
| MMH Cranford | 71.1% | 138.6% | 109.9% | 122.5% | 106.3% |
| MMH Fairbairn | 98.4% | 83.9% | 102.2% | 98.2% | 106.3% |
| MMH Mackaness | 81.4% | 39.0% | 101.0% | 64.7% | 43.8% |
| MMH Prichard | 93.7% | 104.3% | 68.0% | 129.9% | 101.2% |
| MMH Robinson | 112.3% | 90.3% | 100.5% | 90.1% | 98.8% |
| NPS Rose | 129.3% | 99.3% | 108.6% | 96.7% | 93.8% |
| WMH Bracken | 97.7% | 80.8% | 73.0% | 79.5% | 74.6% |
| WMH Maple | 94.3% | 102.4% | 100.7% | 110.4% | 136.0% |
| WMH Willow | 108.8% | 109.0% | 118.2% | 88.2% | 114.3% |
| **Total** | **96.6%** | **93.2%** | **94.4%** | **96.1%** | **97.4%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Medium Secure** | **94.4%** | **94.3%** | **88.8%** | **100.8%** | **98.7%** |
| FMH 21 The Avenue | | 112.5% | | 106.2% | 56.7% |
| MMH 23a The Avenue | | 98.8% | | 101.4% | 66.7% |
| MMH Cranford | 67.6% | 141.1% | 94.5% | 131.1% | 104.6% |
| MMH Fairbairn | 82.3% | 86.2% | 101.1% | 93.2% | 106.3% |
| MMH Mackaness | 90.3% | 53.7% | 96.2% | 79.9% | 53.0% |
| MMH Prichard | 93.5% | 108.9% | 76.6% | 121.4% | 106.0% |
| MMH Robinson | 116.0% | 95.0% | 102.2% | 89.4% | 105.2% |
| NPS Rose | 122.1% | 102.6% | 101.7% | 95.1% | 94.2% |
| WMH Bracken | 81.5% | 69.9% | 63.1% | 75.1% | 79.2% |
| WMH Maple | 99.1% | 99.6% | 108.5% | 158.7% | 120.5% |
| WMH Willow | 117.3% | 107.0% | 90.3% | 102.7% | 114.3% |
| **Total** | **94.4%** | **94.3%** | **88.8%** | **100.8%** | **98.7%** |

Medium Secure have had a fluctuating staffing fill rate picture over the last 3 months. They have had total qualified and HCA fill rates consistently above 90% both day and night, with the exception of the month of June, whereby their night qualified fill rate was 88.8%. Similarly to other divisions, MSU's area of challenge and focus continues to be around reaching their qualified planned position consistently.

Cranford is planned to have 3 qualifieds in the day, however often one is being redeployed to support other wards within the division, or the shift remains unfilled. Similarly, both Bracken and Prichard are planned to have 2 qualifieds at night, with the 2nd qualified frequently being redeployed across the site.

Both Bracken and Mackaness have been flexing down for periods of time, due to reductions in their occupancy, enhanced support and clinical acuity, and reflects some of their reduced fill rates. This has been a clinically led and well managed reduction, and has allowed resource to be redeployed to wards with rising clinical acuity.

One clinical action card was implemented within MSU within the last 3 months.

*05/06/22 – MSU – No Q on shift*
Implemented on the night of the 5th June across the MSU division. The lone working Q on Bracken got injured during night shift and had to attend A&E. None of the MSU wards had 2 Q's scheduled, so redeployment options were not available within the division. Rose ward also had no Q after midnight, however this was mitigated by the Night Site Co-ordinator basing themselves on the ward. To help mitigate this the following took place; acuity on all wards in MSU were reviewed, contingency options discussed and considered with the SMoS on duty, Q redeployment options from other wards on site was explored, however no capacity. It was clinically agreed that the lowest risk option was for Bracken to be left with no registered nurse physically present on the ward, however Willow would hold the medication keys and provide nursing support if required. HCA staffing within the division was boosted to support and help mitigate this risk.

**Neuro:**

April:

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Neuro** | **97.8%** | **95.2%** | **97.5%** | **118.4%** | **95.8%** |
| NPS 38 Berkeley Close | 0.0% | 71.3% | 18.9% | 85.2% | 50.0% |
| NPS Allitsen | 94.8% | 129.0% | 95.4% | 146.4% | 91.7% |
| NPS Aspen | 102.6% | 98.7% | 104.9% | 143.8% | 84.2% |
| NPS Berkeley Av 19 | | 23.8% | | 66.0% | 100.0% |
| NPS Cherry | 78.4% | 95.3% | 94.5% | 100.0% | 100.0% |
| NPS Elgar | 120.9% | 130.6% | 91.3% | 140.6% | 87.2% |
| NPS Elm | 89.4% | 95.6% | 96.1% | 103.4% | 109.1% |
| NPS Fenwick | 110.8% | 92.8% | 107.3% | 107.3% | 99.7% |
| NPS Redwood | 92.3% | 105.6% | 95.4% | 97.6% | 87.5% |
| NPS Tallis | 103.5% | 93.5% | 102.0% | 175.4% | 109.0% |
| NPS Tavener | 92.9% | 77.5% | 86.3% | 96.4% | 94.0% |
| NPS Walton HD | 106.0% | 84.3% | 101.1% | 111.0% | 101.0% |
| **Total** | **97.8%** | **95.2%** | **97.5%** | **118.4%** | **95.8%** |

May

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Neuro** | **103.4%** | **98.1%** | **101.2%** | **117.1%** | **97.1%** |
| NPS 38 Berkeley Close | | 70.4% | 15.6% | 98.1% | 50.0% |
| NPS Allitsen | 109.7% | 130.7% | 104.2% | 134.4% | 93.1% |
| NPS Aspen | 104.0% | 115.2% | 100.4% | 147.0% | 79.8% |
| NPS Berkeley Av 19 | 78.8% | 15.8% | | 75.0% | 100.0% |
| NPS Cherry | 84.5% | 108.9% | 102.7% | 114.8% | 111.1% |
| NPS Elgar | 107.9% | 90.6% | 108.2% | 105.0% | 86.8% |
| NPS Elm | 104.3% | 92.2% | 104.2% | 106.4% | 109.1% |
| NPS Fenwick | 101.1% | 108.3% | 103.8% | 107.7% | 100.0% |
| NPS Redwood | 95.1% | 104.0% | 100.3% | 97.4% | 94.0% |
| NPS Tallis | 114.8% | 116.0% | 103.4% | 201.2% | 103.2% |
| NPS Tavener | 103.0% | 75.5% | 87.6% | 92.6% | 93.3% |
| NPS Walton HD | 108.4% | 84.1% | 100.8% | 99.0% | 107.7% |
| **Total** | **103.4%** | **98.1%** | **101.2%** | **117.1%** | **97.1%** |

June

| Directorate | Day | | Night | | |
|---|---|---|---|---|---|
| | Fill Rate (Reg) | Fill Rate (HCA) | Fill Rate (Reg) | Fill Rate (HCA) | Occupancy % (Vs Budget) |
| **Neuro** | **104.3%** | **98.0%** | **102.0%** | **119.4%** | **98.1%** |
| NPS 38 Berkeley Close | | 76.8% | 26.6% | 70.0% | 50.0% |
| NPS Allitsen | 106.4% | 137.4% | 110.4% | 165.1% | 114.4% |
| NPS Aspen | 87.5% | 113.4% | 102.9% | 141.9% | 65.4% |
| NPS Berkeley Av 19 | 37.9% | 16.2% | | 74.6% | 100.0% |
| NPS Cherry | 82.3% | 99.4% | 98.3% | 108.2% | 100.0% |
| NPS Elgar | 105.6% | 104.1% | 103.1% | 123.1% | 91.4% |
| NPS Elm | 99.1% | 92.6% | 116.7% | 107.0% | 108.2% |
| NPS Fenwick | 106.2% | 89.2% | 103.0% | 101.1% | 100.0% |
| NPS Redwood | 85.1% | 103.8% | 100.4% | 93.3% | 100.0% |
| NPS Tallis | 131.1% | 117.0% | 92.8% | 202.7% | 100.0% |
| NPS Tavener | 137.5% | 74.1% | 92.1% | 95.3% | 93.6% |
| NPS Walton HD | 103.8% | 81.8% | 101.0% | 99.3% | 107.7% |
| **Total** | **104.3%** | **98.0%** | **102.0%** | **119.4%** | **98.1%** |

Neuropsychiatry has generally seen an improving, stable staffing picture over the last 3 months. Total fill rates for both qualifieds and HCA's have been above 95%. For the month of June these have been above 100%, with the exception of the day HCA fill rate at 98%.

38 Berkley Close and 19 the Avenue have separate planned numbers, however share staffing resource and have been generally been scheduling into one house, and redeploying on the day. This has caused some inconsistency with how the fill rate is reflected. Options to rectify this have been explored within the division, and these houses will now be planned and scheduled for separately to prevent this inconsistency in future reports. Despite what appears to be some reduced fill rates, both houses have been flexing down from their base number day and night due to a reduction in occupancy and ES levels.

Walton have also been flexing down below baseline during the day due to a reduction in clinical acuity and ES levels. Both the Houses and Walton have then been able to support the division and redeploy resource and care hours, to wards that have seen increasing acuity and ES levels; most significantly on Tallis and Allitsen.

The reduced qualified fill rates at night on Tavener and Tallis are due to both wards being planned to have 1.4 qualifieds at night (1 all night plus a twilight), however the twilight qualified is frequently redeployed within the division or CAMHS to support the need for a minimum of one qualified per ward.

The division has not implemented any action cards over the last 3 months.

## 4. Right Skills

Boards should ensure clinical leaders and managers are appropriately developed and supported to deliver high quality, efficient services, and there is a staffing resource that reflects a multidisciplinary team approach.

### 4.1 Mandatory Training Figures

| Division | Apr-2022 | May-2022 | Jun-2022 |
|---|---|---|---|
| ASD & LD | 90% | 89% | 88% |
| Birmingham | 93% | 92% | 91% |
| CAMHS | 92% | 90% | 89% |
| Essex | 95% | 93% | 92% |
| Low Secure & Specialist Rehab | 92% | 91% | 91% |
| Medium Secure | 90% | 88% | 88% |
| Neuro | 90% | 90% | 88% |
| **Charity Total** | **92%** | **91%** | **90%** |

| Mandatory Training KPI's | Basic Life Support | | | Immediate Life Support | | | Infection Control | | | Safety Intervention Training | | | Safeguarding - Level 3 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Division | # Target | # Out of date | KPI % | # Target | # Out of date | KPI % | # Target | # Out of date | KPI % | # Target | # Out of date | KPI % | # Target | # Out of date | KPI % |
| ASD & LD | 438 | 133 | 70% | 118 | 5 | 96% | 575 | 16 | 97% | 517 | 133 | 74% | 134 | 18 | 87% |
| Birmingham | 231 | 78 | 66% | 103 | 3 | 97% | 344 | 2 | 99% | 320 | 67 | 79% | 110 | 20 | 82% |
| CAMHS | 137 | 36 | 74% | 26 | 1 | 96% | 172 | 1 | 99% | 147 | 43 | 71% | 149 | 16 | 89% |
| Essex | 165 | 34 | 79% | 65 | 6 | 91% | 238 | 1 | 100% | 219 | 45 | 79% | 71 | 12 | 83% |
| Low Secure & Specialist Rehab | 268 | 71 | 74% | 92 | 2 | 98% | 367 | 3 | 99% | 340 | 84 | 75% | 107 | 11 | 90% |
| Medium Secure | 352 | 106 | 70% | 103 | 6 | 94% | 468 | 12 | 97% | 428 | 116 | 73% | 126 | 13 | 90% |
| Neuro | 349 | 97 | 72% | 111 | 5 | 95% | 478 | 8 | 98% | 422 | 113 | 73% | 132 | 19 | 86% |
| **Charity Total** | **2224** | **629** | **72%** | **676** | **33** | **95%** | **3381** | **54** | **98%** | **2600** | **636** | **76%** | **975** | **132** | **86%** |

*June 2022 KPI's

The Charity's total mandatory training compliance has seen a slight progressive decline over the last 3 months, from 92% in April to 90% in June, and this can be seen across all divisions and sites.

**Area of Strength**
Infection Control and ILS continue to be an area of strength for Charity wide compliance, with infection control at 98%, and ILS at 95%. With the Covid restrictions having been reviewed and recently increased again, due to a number of new outbreaks across wards, the compliance with infection control is reassuring. In addition, Learning & Development have been working very closely with divisions to provide the right level of ILS training course availability to meet the demand, and help improve compliance in this area. With some of our qualified nursing resource challenges, it is vital that our nurses remain skilled, confident and competent.

**Risk Area**
Safeguarding level 3 face to face training is still the area where most improvement is required. Charity total compliance as of April 2022 was 84% and this has only increased to 86% as of June 2022. The Learning and Development Team are continuing to explore how to replicate the recent success with ILS figures, within Safeguarding compliance. Another area of risk is BLS, which is currently at 72%. The BLS training used to be included within the Essential Skills Refresher, however has recently been separated out from this, and requires an individual booking. There was some confusion around this amongst some of the divisions, which may have contributed to this low figure. This has now been clearly communicated to NM's and divisions which should see uptake improve.

Our Safety Intervention Training (SIT) is also a risk area for the charity as it is sitting at 76%. This is a two day course and there have been some occasions whereby staff have been pulled back from the training to support the ward. This remains a risk as we continue to have challenges reaching planned levels on some days across all wards. However, some divisions are now ensuring senior divisional oversight and review of the days staffing, and capacity support from the wider MDT and clinical team, before cancelling staff training.

## 5. Safety & Quality Indicators

The indicators considered within this report reflect the approach taken in staffing reviews and reflect the current NHS England recommendations.

### 7.1 Incidents:

| | Apr 22 | May 22 | Jun 22 |
|---|---|---|---|
| St Andrews All (Rate per 1000 OPDs) | 118.68 | 117.63 | 111.94 |
| ASD/LD | 110.01 | 131.8 | 130.18 |
| Birmingham | 20.77 | 13.16 | 26 |
| CAMHS | 838.98 | 709.63 | 713.47 |
| Essex | 50.52 | 51.22 | 50.11 |
| LSSR | 137.1 | 169.86 | 165.19 |
| MSU | 70.67 | 56.59 | 67.22 |
| Neuro | 137.58 | 142.56 | 118.46 |

As a Charity total, total incident levels from April to June have progressively reduced from 118.68 to 111.94 in June; although this steady reduction isn't seen across all divisions. The incidents above can be separated out into staffing related incidents as below:

| | Apr 22 | May 22 | Jun 22 |
|---|---|---|---|
| **Total Count** | 37 | 15 | 29 |
| Level 1 – No Harm | 30 | 10 | 25 |
| Level 2- Low | 7 | 3 | 4 |
| Level 3 – Moderate | 0 | 2 | 0 |

From the total of 29 staffing related incidents reported in June, all of these were for Neuropsychiatry, with 20 specifically for Allitsen ward. On further review of these incidents, most of them fell under the category of 'missed patient observation', and covered incidents whereby for short periods enhanced support levels were reduced. However, these were all deemed clinically manageable and no clinical harm came to the patient and explains why no action cards were raised for this period. After discussion with the division, it is felt that reporting levels are good with staff able to recognise when tasks haven't been completed, and report to ensure openness and transparency despite no clinical harm being caused. It has also already been identified within the division as a 'Lessons Learnt', to ensure and support staff to follow our staffing escalation process, and ensure ward teams raise any inability to complete tasks or intermittent checks immediately with the bleep holder, in order to seek redeployment.

Of the total 15 reported incidents in May, 12 of these were for Neuropsychiatry, 2 for CAMHS and 1 for ASD/LD. On review, a similar theme has been noted as June, whereby incidents of 'Missed patient observation' have been reported in Neuro, without any clinical harm or incident. The division is now holding regular enhanced support panels, to thoroughly review the clinical need and management plan for observation levels; 1 has already been completed for Allitsen, and another is scheduled for Tallis in July.

For the two moderate incidents reported in May, one was for the CAMHS division following an implementation of two action cards (reported further above) for 'Shortage of staff' and 'No Q on shift'. The other incident reported was for Hawkins, whereby a lack of staff response was highlighted during a physical aggression incident with a patient. There is now a process to investigate non response of staff to group alerts and medical emergencies. This would first be reviewed by the divisional bleep holders and night site co-ordinators, who now collate and document response plans throughout the day for each of their wards. Should wards not respond and this hadn't have been escalated to the bleep holder, this is immediately followed up with the ward/NM. In addition, each division now completes daily radio checks with their wards and this is audited via the site report. The divisional bleep holder and Senior Manager on Site, now take lead roles in directing and co-ordinating response over the radio where required.

**7.3 Complaints:**

Over the last 3 months, PALS and Complaints have received a total 27 staffing related concerns/complaints covering all three sites. These can be broken down into the following categories:

Staff attitude/behaviour: 22
Staff availability: 4
Staff competence: 1

These have all been thoroughly reviewed, and some remain in the process of being investigated and a response being formulated. Out of the 27, the 5 below relate specifically to staff availability and/or staffing levels.

ASD/LD – Acorn – Staff Availability
*Patient is unhappy that, due to low staffing levels, her 2 hour leave to see her partner is not being facilitated as agreed by the doctor.*

ASD/LD – Oak - Staff Availability
*Due to staff shortages ES could not do puzzles*

Essex- Danbury – Staff Availability
*Patient states that the MDT are never available on the days that they need them. Alleges community meetings have been aborted as the MDT fail to turn up and ward rounds proceed in an unorderly manner.*

Essex – Benfleet – Restrictive practice (however elements relating to staffing)
*Patient has raised following concerns:*
*He is supposed to have town leave once a week for 4 hours but he does not always get to use it and it reduces in time when he does use it. Was not able to take it this week at all.*
*Staff shortages, have to bring staff from other areas.*

Low Secure – Naseby – Staff Availability
*Hairdresser's appointment was made and patient had paid £50 deposit. This was cancelled due to there not being enough staff on the ward to facilitate. When re booking patient was informed it may be cancelled again for same reason.*

Each concern and compliant raised is thoroughly investigated by the wider clinical team, with both immediate and longer term lessons learnt drawn from them. A recurrent theme in all of the 5 concerns above, is in relation to communication between staff and patients, and the need for this to be improved in some areas. Lessons learnt are shared at ward level, divisionally, and also charity wide where required. A number of divisions have recently added a specific agenda items for 'lessons learnt' within their daily divisional huddle. This is encouraging wards to share any learning immediate, with the view to prevent this from happening again in the future.

## 8 Moving Forward & Charity Developments

### 8.1 Allocate – E-Rostering Update

In an effort to make the new eRostering tool as simple to use as possible for our nursing staff, extra time was needed to make processes simpler and training more straight forward. This delay in getting the product to the best quality has resulted in new dates for training and launch. Training for our Nurse Managers and Clinical Nursing Leaders is now planned to start in August, leading to rosters being built for each ward by the end of August. All take charge nurses and staff will be able to join drop in sessions to learn the new system during the summer. The charity is now looking to implement Auto Roster in the first roll out phase, and discussions remain underway to support the smooth implementation of this for all staff.

### 8.2 MHOST Acuity Training

As part of the Workforce Safeguards workstream, our NHS expert provided MHOST acuity training to our ward leaders in April, which included over 30 of our CNLs and NMs across the Northampton, Birmingham and Essex sites. As part of the Developing Workforce Safeguards guidance, it is a requirement that there are staff trained in the application of this tool and its descriptors, to ensure accurate data collection when rating our patients; and to provide assurance to the board that this tool is being used effectively and in line with its license. We have a further training date scheduled for the end of July to capture more of our senior ward leaders. Following this, our Safer Staffing Matron will be able to continue rolling out the training across divisions and this will include roll out to all levels of qualified nurses. The successful rollout of this training which help us ensure that for our next set of establishment reviews (in January 2023) we have enough leaders trained to do this effectively, and triangulate with professional judgement, and quality/safety data.

**Risks for the Board to Consider**

- Increased establishment gap across the Charity for both qualified and unqualified staff, as we move to increase our proportion of regular staff and reduce our reliance on WorkChoice and agency.
- Our current inconsistencies with rostering and scheduling at both ward and divisional level, are impacting on our ability to deploy our regular substantive staff most effectively, and seeing an increased need for overtime and Workchoice shifts (where not always required).
- There remains an increased reliance on WorkChoice and agency. This is due to continued absence levels, our current establishment gap, and the need to support temporary flex uplifts due to both increased acuity and demand, which is seeing wards needing to work above their planned number. This is a risk due to impact on continuity of patient care, patient experience and a potential impact on staff wellbeing due to the pressures of working alongside and supporting unfamiliar staff.
- The charity continues to have challenges in recruiting servery staff, as per our planned model to complement the roll out of MHOST. Birmingham and Essex currently have no servery support, whilst Northampton also hasn't reached its full complement of 1 assistant per 2 wards. Wards without this support continue to receive a 0.3 uplift in their nursing number. However, with our current nursing establishment gap, this is only adding additional pressure to reach an increased nursing requirement.
- There are still some instances of refusals to redeploy, and CAMHS in particular continue to be most affected by this. This is a significant risk for the division, who have had challenging staffing levels over the last 3 months, including an increased qualified gap. Although our newly refined absence and refusal to redeploy management process is reducing the number of these instances, there are still occurring.

**Proposal**

- The Safer Staffing Matron (SSM) will continue to support the established Developing Workforce Safeguards work to provide assurance of safe staffing across the Charity.
- SSM will work closely with the Heads of Division to complete and agree the planned June establishment review; based on clinical discussion, professional judgement and a review of quality/safety data.
- SSM will continue to closely review flex management across all divisions and sites.
- The SSM, Operations and Workchoice Leads will continue to work closely with the Senior Ward leaders of the Charity as we plan to roll out Allocate in the next few months. This will be key to changing and improving some of our scheduling behaviours and practices; which is where we continue to see lots of inefficiencies.

| Paper for Board of Directors | |
|---|---|
| **Topic** | Modern Slavery Statement |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **11** |
| **Author** | Rachel Brown, Head of Commercial Legal |
| **Responsible Executive** | Martin Kersey |
| **Discussed at Previous Board Meeting** | Annual Modern Slavery Statement approved at Board Meeting last Sept 2020 |
| **Patient and Carer Involvement** | Patients and Carers have not been involved |
| **Staff Involvement** | Staff have not been involved |
| **Report Purpose** | Review and comment ☐<br>Information ☐<br>Decision or Approval ☒ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐ |
| **Strategic Focus Area** | Education and Training ☐<br>Finance & Sustainability ☐<br>Service Innovation ☐<br>Quality ☐<br>Research & Innovation ☐<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☐ |
| **Committee meetings where this item has been considered** | None |

**Report Summary and Key Points to Note**

We are required to publish a Modern Slavery Statement on or website every year, the Modern Slavery Statement has been refreshed with current staff numbers and an update on purchasing actions and is submitted for approved by Board

# Modern Slavery and Human Trafficking Statement

This statement is made pursuant to s54(1) of the Modern Slavery Act 2015 and sets out St Andrew's Healthcare's modern slavery and human trafficking statement in relation to actions and activities for the financial year ending 31 March 2022.

We are committed to preventing slavery and human trafficking in our business activities and to ensuring that our supply chains are free from slavery and human trafficking.

**Organisational Structure**
We are a charity and a unique and influential pioneer in mental health, with a reputation grown over 180 years. We have sites in Northampton, Birmingham, Essex and Nottinghamshire employing over 4,200 people, providing specialist and secure care and treatment in mental health and neuropsychiatry.

**We have adopted the following practices, policies and approaches to help us address any potential slavery or human trafficking risks:**

**People**
- We have robust procedures in place for recruiting our workforce. We ensure that all applicants are legally entitled to work in the UK. All staff undergo a full DBS (Disclosure & Barring Service) check.
- We pay all staff above the National Minimum Wage.
- Our directors are checked against the Fit and Proper Person Regulations to ensure they are compliant with these Regulations before they take up their position.
- Our Staff Code of Conduct helps promote a culture where transparency, honesty and fairness are the norm. Our Code forms part of our contractual terms with our staff.
- Staff training (including Director training) is continually reviewed and updated to ensure every person has awareness of our regulatory compliance responsibilities including modern slavery, safeguarding and anti-bribery. Such training is mandatory and completion is actively monitored.

**Freedom to Speak Up (Whistleblowing)**
- Our workforce and service users, as well as anyone we do business with, are encouraged to report and expose unethical or inappropriate activities, procedures or behaviour within our business and supply chain.
- Our Freedom to Speak Up and Whistleblowing Procedure is intended to make it easy for disclosures to be made without fear of consequence. The policy encourages people to raise concerns directly with their line manager, HR, any senior executive or through the Charity's appointed Freedom to Speak Up Guardians. There is also free access to an independent service through which to report any concerns.
- Any modern slavery or fraud concerns raised are thoroughly investigated by us and actioned appropriately in accordance with our robust procedures and standards and outcomes reported through our Board of Directors and, where relevant, our Audit & Risk Committee.

**Diversity and Equality**
We are fully committed to proactively promote diversity, equality of opportunity and human rights for all and to creating a culture of inclusivity for the people who provide and use our services. The Charity's Board reviews the Charity's Diversity and Inclusion report and approves the Diversity and Inclusion Strategy annually.

**Procurement & Supply Chain**
The Charity is committed to ensuring that its suppliers and supply chain adhere to the highest standards of ethics and integrity. We achieve this through our relationships and contractual requirements:
- Our procurement guidance for staff ensures that all new suppliers are appointed in conjunction with our Procurement Team so appropriate checks can be taken.
- Our procurement process includes (within our pre-qualification questionnaire) questions regarding the Modern Slavery Act. Any supplier unable to declare their compliance with the Act will be excluded from the procurement process.
- Our standard procurement contracts contain a requirement for the supplier to ensure ongoing compliance with the Modern Slavery Act and allow us to terminate the relationship, should compliance not be maintained.

- We have a Supplier Code of Conduct which includes a specific requirement to comply with Act.

**Review of Effectiveness**
Whilst we have had no modern slavery issues reported to date, we are committed to regularly reviewing our procedures and seek to continually improve our practices to prevent modern slavery and human trafficking.

In 2021/22, we will continue to review our safeguarding strategy, policy and procedures and general training plan to ensure that modern slavery and human trafficking are adequately covered.

The Board approved this statement at its meeting on [ ] 2022.

*Signed:*

……
Prof. Oliver Shanley, OBE, Chief Executive, St Andrew's Healthcare

*Dated:*
[ ] 2022

| Paper for Board of Directors | |
|---|---|
| **Topic** | Board Assurance Framework & Board Update |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **12** |
| **Author** | Duncan Long, Company Secretary and Sajid Ali, IA & Risk Manager |
| **Responsible Executive** | Professor Oliver Shanley, Chief Executive (interim) |
| **Discussed at Previous Board Meeting** | May 2022 Board of Directors |
| **Patient and Carer Involvement** | Not specifically for the update. |
| **Staff Involvement** | Not specifically for the update, however individual items relating to the process have been discussed with the appropriate personnel where required, with many involved in the actual development of the BAF. |
| **Report Purpose** | Review and comment ☒<br>Information ☐<br>Decision or Approval ☒<br>Assurance ☐ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐ |
| **Strategic Priority Area** | Education and Training ☒<br>Finance & Sustainability ☒<br>Service Innovation ☒<br>Quality ☒<br>Research & Innovation ☒<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☒ |
| **Committee meetings where this item has been considered** | Audit & Risk Committee meetings and Charity Executive meetings |

**Report Summary and Key Points to Note:**

The purpose of this paper is to highlight the progress made with the continued development and implementation of the Charity's Board Assurance Framework (BAF) ) as well as to provide the first Board BAF Report, highlighting the current position of the Strategic Risks managed within the BAF.

As discussed previously, the BAF enables the Board to monitor the ongoing principal risks to the implementation and achievement of the Charity's strategic objectives. Once embedded and used effectively, the BAF should drive the agendas and focus of the Board and its sub-committees in relation

to strategic risk management, as well as maintaining a degree of focus on the delivery of strategic milestones and objectives.

Following the approval of the BAF Template and BAF Process at the May Board, a series of workshops, meetings and updates have been completed with the responsible Executives and their designated senior management for the agreed eight Strategic Risks being monitored via the BAF. The output of these sessions can be seen in the updated templates for each of the Strategic Risks (Appendix 01).

The Charity's BAF is making good progress and we believe it is well on its way to becoming an effective tool for the Board and Executives to manage the strategic risks and aid the achieving of agreed Charity objectives. Once the BAF process is embedded, the assurance levels for each Strategic Risk will be determined by the Board as part of the bi-monthly review process, however to aid review and discussion at the July Board meeting we are including assurance levels provided by each Executive Lead that have been reviewed and agreed at the Strategy Executive meeting on 13 July.

The reviews have identified clear links between many of the risks and associated controls and the degree of these links and their impact will be better known as the process develops. Whilst a number of risks have been recorded as having only limited levels of assurance, we should remain mindful that we are in the infancy of our strategy delivery (being only a few months into a long journey of five (plus) years) and we would expect to see these assurance levels improve over time and in-line with the planned agreed actions.

The Board is asked to acknowledge that the implementation of the new BAF is an iterative process and that there remains work to do on the identification of any potential gaps in the stated control/mitigation and sources of assurance, along with the appropriate actions required to address them. These areas are the main focus for the next round of scheduled BAF review meetings with the Executives and designated management.

**The Board is asked to review the updated BAF, and:**

1 - Review the proposed revised strategic risk description for Strategic Risk number 7, and if in agreement approve the new title and description.

2 - Review the information recorded so far and the levels of assurance stated and if in agreement approve the initial assurance ratings, or through discussion propose and agree alternative levels of assurance.

3 – Confirm its collective response to the key questions contained within the Board BAF Update for July 2022.

**Progress of Strategic Objectives:**

As agreed at previous Boards, the Board can maintain sight over progress with achieving the Charity's Strategic Objectives via the processes in place to manage and mitigate the Strategy Delivery risk (risk number one within the BAF) and key to this is the Strategic Milestone Tracker and Executive Summary. This is completed each month and reviewed and discussed in detail at the Executive Meeting immediately preceding the Board. The Executive Summary and Tracker is attached as Appendix 2.

The report provides a narrative for activity and progress for each priority area. Much of the work in this first period has been focussed on the enabling elements of the strategy (quality, workforce, resilience & agility, finance & sustainability) seeking to establish stability within these critical areas of focus. Of the 17 milestones due in quarter 1 2022/23, 13 have been achieved. Of the 4 that have not been achieved the most material of these are:

- Establish Business Development Team by Q2. Recruitment to the Business Development Team was impacted by an unsuccessful first recruitment round, however appointments have now been made. This delay will have an impact on the subsequent milestones of completing a broad options analysis and outline of opportunities, ahead of a gateway review and approval at the September Board. This review will be deferred until the November Board.

- Establish an enlarged and combined 'research and education hub' in the historic Northampton hospital building with input from our academic and industry partnerships: achievement of this milestone has been impacted by the absence of operational leadership and organisational clarity around the underpinning architecture and structure for our research and education ambitions. Our intent is to resolve this through Q2/3 2022/23 and reschedule delivery of the milestone for Q4 2022/23. This will have an impact on the milestone associated with the investment in Research and Innovation but is not expected to adversely affect other plans.

**Future progress reporting to Board:**

Whilst the SMT and Executive Summary process has been introduced to provide a detailed review mechanism to understand progress and provide assurance on the level of progress, whilst managing the Strategy Delivery risk, it would be beneficial to gain further understanding of how the Board wishes to see progress updates for the strategy moving forward. For instance, does the Board wish:

1 – To receive the SMT and Executive Summary at each Board as part of the BAF Report?

2 – To have the SMT and Executive Summary as a separate bi-monthly paper, either in part one or part two?

3 – To receive a compressed summary of the progress within the BAF Report?

4 – To hold periodic deep dives into strategy progress at future Boards, or at Board Development Sessions?

5 – To schedule twice yearly Board Strategy Days to have in-depth discussions on the Strategy, including progress, risks and potential amendments.

**In summary:**

The Board is asked to review the inaugural Board BAF Report and provide any feedback or comment on its format and content, and if any further information is required within it.

The Board is also asked to respond to the three questions pertaining to the BAF (as above), and to provide feedback, and preferred options for reporting strategy progress to the Board as requested above.

**Appendices -**

Appendix 1 – Board Assurance Framework

Appendix 2 – Strategic Milestone Tracker and Executive Summary – 13 July 2022

# Board of Directors - Board Assurance Framework

## Introduction & purpose of the report

The purpose of this paper is to highlight the progress made with the continued development and implementation of the Charity's Board Assurance Framework (BAF) as well as to provide the first Board BAF Report, highlighting the current position of the Strategic Risks managed within the BAF.

As discussed previously, the BAF enables the Board to monitor the ongoing principal risks to the implementation and achievement of the Charity's strategic objectives. Once embedded and used effectively, the BAF should drive the agendas and focus of the Board and its sub-committees in relation to strategic risk management, as well as maintaining a degree of focus on the delivery of strategic milestones and objectives. The BAF also records actions to address any gaps in controls and assurances so that implementation can be monitored by both the Board and senior management.

The BAF provides the Board with a formal opportunity to oversee, discuss and challenge the current risks required in order to most likely achieve the strategic objectives of the Charity. The BAF facilitates a proactive approach to assessing the controls in place, assurances being provided, action being taken and the progress being made against the Charity's strategic objectives.

## Executive Summary

Following the approval of the BAF Template and BAF Process at the May Board, a series of workshops, meetings and updates have been completed with the responsible Executives and their designated senior management for the agreed eight Strategic Risks being monitored via the BAF. The output of these sessions can be seen in the updated templates for each of the Strategic Risks (Appendix 01 – BAF Templates Jul 2022).

The Charity's BAF is making good progress and we believe it is well on its way to becoming an effective tool for the Board and Executives to manage the strategic risks and aid the achieving of agreed Charity objectives. Once the BAF process is embedded, the assurance levels for each Strategic Risk will be determined by the Board as part of the bi-monthly review process, however to aid review and discussion at the July Board meeting we are including assurance levels provided by each Executive Lead that have been reviewed and agreed at the Strategy Executive meeting on 13 July.

The reviews have identified clear links between many of the risks and associated controls and the degree of these links and their impact will be better known as the process develops. Whilst a number of risks have been recorded as having only limited levels of assurance, we should remain mindful that we are in the infancy of our strategy delivery (being only a few months into a long journey of five (plus) years) and we would expect to see these assurance levels improve over time and in-line with the planned agreed actions.

Previous projects to implement an effective BAF (or also previously titled Strategy Assurance Framework) were not embedded effectively or sustained, as the initial development stages were generally completed by the relevant support functions and then presented to the responsible Executives or senior management for review and approval. With the updates completed by the support functions as well, resulting in a degree of ambiguity over the ownership and accountability of the process and end result. Whilst the iterative and more structured approach to the development and implementation of the new BAF has resulted in a longer than first anticipated project timeline, the results to date indicate it has been a worthwhile change of approach. The Exec leads and their designated management have been fully involved in the development and populating of the risk templates and there is a clear approach agreed for continuing this in line with future Board meetings.

The Board is asked to acknowledge that the implementation of the new BAF is an iterative process and that there remains work to do on the identification of any potential gaps in the stated control/mitigation and sources of assurance, along with the appropriate actions required to address them. These areas are the main focus for the next round of scheduled BAF review meetings with the Executives and designated management.

## July 2022 Periodic analysis and key information to note:

## BAF Summary Dashboard (as at July 13th 2022):

The following summary dashboard provides an overview on the strategic risks held within the BAF:

| # | Strategic Risk | Exec Lead | Appetite Category | Appetite level | Current risk score | Appetite Tolerance | Change in risk score since last review | Initial Score (pre-mitigation) | Overall level of assurance |
|---|---|---|---|---|---|---|---|---|---|
| 1 | **Strategy Delivery** | CEO | Performance & service sustainability | Moderate (>12) | Possible (3)x Major (4) = 12 | Within appetite | No change - first review | Likely (4) x Catastrophic (5) = 20 | Limited |
| 2 | **Quality of Services** | Chief Nurse | Quality | Low (>12) | Possible (3)x Catastrophic (5) = 15 | Exceeds appetite | No change - first review | Likely (4) x Catastrophic (5) = 20 | Limited |
| 3 | **Financial Objectives** | CFO | Financial Sustainability | Moderate (>12) | Possible (3)x Major (4) = 12 | Within appetite | No change - first review | Likely (4) x Catastrophic (5) = 20 | Adequate |
| 4 | **Workforce** | EHRD | Workforce | Moderate (>12) | Possible (3)x Major (4) = 12 | Within appetite | No change - first review | Likely (4) x Catastrophic (5) = 20 | Partial |
| 5 | **Organisational Culture** | CEO | Workforce | Moderate (>12) | Possible (3)x Major (4) = 12 | Within appetite | No change - first review | Likely (4) x Major (4) = 16 | Adequate |
| 6 | **Partnership Working** | CEO | Partnerships | High (>15) | Possible (3)x Major (4) = 12 | Within appetite | No change - first review | Almost certain (5) x Major (4) = 20 | Partial |
| 7 | **Strategic Assets and Estates Management** | Dir of E&F | Performance & service sustainability | Moderate (>12) | Possible (3)x Major (4) = 12 | Within appetite | No change - first review | Likely (4) x Major (4) = 16 | Partial |
| 8 | **Service Innovation** | EMD | Research & Development | High (>15) | Likely (4)x Major (4) = 16 | Exceeds appetite | No change - first review | Almost certain (5) x Major (4) = 20 | Limited |

**New or closed strategic risks:**

No new risks have been proposed since the May Board of Directors, and no strategic risks are being proposed for closure. Whilst no new risks are proposed, it is proposed that one of the risks is updated. Please see below in reference to Strategic Risk number 7.

**Changes to risk score / ratings since last report:**

There are no changes to report as this is the first report on strategic risk scores, however the BAF Summary Dashboard does highlight both the initial and current risk scores as reviewed and agreed with the Executive Leads, Company Secretary and IA & Risk Manager during the reviews.

It is worthy of note however that some of the "current" risk scores are likely to change as more work is done to develop the BAF process and further consideration is given to gaps in control/mitigation and sources of assurance. The area to focus in our next rounds of BAF related meetings would be towards the further detailing on controls and its effectiveness.

**Risk appetite**:

The Risk Appetite categories recorded for each Strategic Risk have been selected following discussions with the Exec Leads and are seen as the most appropriate fit to allow effective discussions and challenge on the potential decisions taken in relation to the identified risks. The Risk Appetite category links to the risk and not the Strategic Priority area.

As shown in the BAF Summary Dashboard, two of the eight risks (Quality of Services and Service Innovation) held within the BAF currently exceed the Charity's appetite for their assigned risk appetite category. The work to identify current control/mitigation and assurance gaps will also identify the necessary actions required to bring the risk within the appetite. Whilst the remaining six risks are all within their assigned risk appetite, they are at the higher end of the tolerance scale and actions should still be agreed to reduce the risk even further wherever possible.

**Committee oversight:**

This area remains work-in-progress and will be developed in conjunction with the Chairs and Exec Leads of the applicable committees to establish the most appropriate form of oversight and the levels of assurance than can be provided.

**Significant updates of note (since last report):**

All the strategic risks held within the BAF have undergone considerable review with the Executive Leads and key staff involved in the relevant strategic areas. The output of these reviews can be seen on the individual BAF templates for each risk, however some of the key points are detailed below:

<u>1 – Strategy Delivery – Limited Assurance</u>

Whilst the assurance level has been proposed as "limited", it is worthy of note that the Charity's Strategy is relatively new and we remain in the infancy of its delivery. The mitigations and controls in place (and planned) will mature and have a positive impact on the level of assurance that risks are being well controlled and will not prevent the delivery of strategy.

As agreed at previous Boards, the Board can maintain sight over progress with achieving the Charity's Strategic Objectives via this Strategic Risk and key to this is the Strategic Milestone Tracker and Executive Summary. This is completed each month and reviewed and discussed in detail at the Executive Meeting immediately preceding the Board. The Executive Summary and Tracker is attached, (Appendix 02 - SMT and Executive Summary).

The report provides a narrative for activity and progress for each priority area. Much of the work in this first period has been focussed on the enabling elements of the strategy (quality, workforce, resilience & agility, finance & sustainability) seeking to establish stability within these critical areas of focus. Of the 17 milestones due in quarter 1 2022/23, 13 have been achieved.

2 – Quality of Services – Limited Assurance

In a similar vein to the assurance level provided at this time for the Strategic Delivery Risk, the mitigations and controls in place and being implemented to manage the Quality Strategic Risk require further time to take effect across the services provided by the Charity.

As stated above, the current risk score for the Quality of Services risk exceeds the Charity's risk appetite of "Low" (based upon the assigned appetite category of Quality), and therefore will require confirmation of the necessary actions required to bring the risk within the appetite at the next Board. In this instance the agreed risk appetite requires escalation to the Board if the current risk score is equal to or greater than 12. The current risk is scored as 15.

7 – Strategic Assets and Estates Management – Following the review meetings and workshops, it is suggested that this risk description is expanded to accommodate other strategic assets, such as IT and not restricted to just estates related assets and risks. With this in mind, it is proposed to rename the risk as, "Strategic Asset Management" and update the description to state:

*"Failure to acquire and maintain "right-sized" and "fit for purpose" strategic assets; coupled with ineffective management of the estate and IT infrastructure will result in, (i) The inability to expand on the strategic aim relating to provision and fulfilment of community based beds, (ii) Higher cost of maintenance impacting financial sustainability. (iii) Potential breach of regulations, and (IV) Reputational damage. All of which collectively will impede the Charity in achieving its strategic objectives."*

If this change is accepted by the Board, consideration should be given to the most appropriate Executive to lead on the risk. The Director of Estates and Facilities is currently Executive Lead for this risk.

8 – Service Innovation – Limited Assurance

A number of mitigation and control gaps have been identified for this risk which indicates the risk is currently not covered adequately. As for the other risks currently highlighted as "Limited Assurance" we would expect to see this improve over the next few months as the process of identifying gaps and actions matures, and some of the initial mitigating actions take effect.

As stated above, the current risk score for the Service Innovation risk exceeds the Charity's risk appetite of "High" (based upon the assigned appetite category of Research & Development), and therefore will require confirmation of the necessary actions required to bring the risk within the appetite at the next Board. In this instance the agreed risk appetite requires escalation to the Board if the current risk score is equal to or greater than 15. The current risk is scored as 16.

**Board Action required:**

The Board is asked to note the contents of this report, and whilst the BAF is not as yet fully completed, the Board are asked to consider:

- Have the correct and appropriate risks been identified and recorded?
- Are the reported risk scores accurate and in line with their understanding?
- Are the identified controls and sources of assurance appropriate?
- Whether any further action is deemed necessary in relation to any of the risks or strategic priority areas?

| | |
|---|---|
| **Duncan Long** | **Mohammed Sajid Ali** |
| **Company Secretary** | **Internal Audit & Risk Manager** |

**Appendix 1 –** Board Assurance Framework

**Appendix 2 –** Strategic Milestone Tracker and Executive Summary – 13 July 2022

| Risk Title | 1 – Strategy delivery | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to develop a robust mechanism to deliver, monitor and report progress on the strategic initiatives will increase the likelihood of one or more of the following: (i) non-achievement of the key Charity strategic objectives, (ii) delayed / non-achievement of strategic milestones (iii) sub-optimal performance on strategic initiatives (iv) adverse publicity and reputational damage (v) insufficiency of initiatives to achieve strategic objectives, and (vi) potential deterioration of, or loss of charitable agency. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Likely (4) x Catastrophic (5) = 20 | | | | | | |
| Exec Lead | CEO | Oversight Committee | Finance & Performance Committee | Current score | Possible (3)x Major (4) = 12 | | | | | | |
| Datix material risk ref(s) | None at present | Risk App. Category | Performance and service sustainability | Risk Appetite | Moderate (12) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Limited | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P,C | Strategy Milestone Tracker | Monthly SMT completed by SRO, collated by Director of Strategy and reviewed by Exec | I (2&3) | TBC |
| P,C | Executive Strategy Milestone Review Deep Dive | Monthly Executive meeting deep dive review of Strategic Priorities and Milestones | I (3) | TBC |
| P,C | Strategy Implementation Plans | Monthly Strategy meeting – Executive Team | I (3) | TBC |
| C | Independent review and audit of the Strategy and its implementation | CQC inspection(s), Well-led review, 3rd Party reviews (NHSIE /W), Internal audits, etc. | I,E (4) | TBC |
| P | Annual planning process | Divisional / Functional strategic plans, Quarterly reviews | I (2,3) | TBC |
| P,C | Awareness campaigns / Strategy awareness programme | YourVoice survey results, Delivery of milestones | I (2,3,5) | TBC |
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| Risk Title | 1 – Strategy delivery | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
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**Gaps in control or assurance**

| Gaps in controls | | | Gaps in assurance | |
|---|---|---|---|---|
| C1 | Process remains in infancy so will need to mature | | A1 | Sufficient time must be allowed at relevant committees to debate, discuss , monitor progress. |
| C2 | Establish timeline for internal audit to undertake a review of process | | | |
| C3 | Reiteration of the 7 strategic objectives as the main focus v/s 7 Strategic priority areas | | | |
| C4 | Strategy Milestone Tracker – Further embedding and completion to be effective | | | |
| C5 | Executive Strategy Milestone Review Deep Dive – Yet to be implemented | | | |
| C6 | Awareness campaigns / Strategy awareness programme – to be developed and launched | | | |

**Actions (what can we do to fill these gaps?)**

| Gap | Action description | | Action owner | Status update | Deadline |
|---|---|---|---|---|---|
| A1 | Undertake evaluation in 6 months to test efficacy of process | | | | |
| A2 | Internal audit to schedule review for Q1 2023-24 (currently Q4 2022-23) | | | | |
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| Risk Title | 2 – Quality of Services | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to deliver high standards of clinical care and/ or deliver services compliant to the required regulations and standards may result in poor patient care, sub-optimal quality of services, and will result in regulatory breaches, regulatory interventions, reputational damage and potential financial implications. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Likely (4) x Catastrophic (5) = 20 | | | | | | |
| Exec Lead | Chief Nurse | Oversight Committee | Quality & Safety Committee | Current score | Possible (3)x Catastrophic (5) = 15 | | | | | | |
| Datix material risk ref(s) | 904, 906, 911, 986, 996 | Risk App. Category | Quality | Risk Appetite | Low (12) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Limited | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P | Embedded clinical governance framework and architecture (RP Monitoring Group, Clinical Gov. Oversight Group) | Clinical Audit, feedback from internal visits | I (2) | TBC |
| P | Quality improvement programme – Buddy workstreams | Weekly QIP meetings, Dashboards, reports | I&E (2,3,5) | TBC |
| P | Committee oversight of clinical activities and their safety and effectiveness (QSC, QSG, LRP Advisory Group) | Committee minutes and action plans | I (2,5) | TBC |
| P | Safer Staffing levels, workforce safeguards and workforce group, Central Staffing Operational hub, Absence project work streams, etc. | Safer staffing report, meeting minutes and action plans, project status updates | I (1,2,3,5) | TBC |
| P | Delivery of evidence based and innovative therapeutic interventions | Dashboards and patient feedback (My voice) | I&E (2) | TBC |
| C | Independent reviews and benchmarking programme (Clinical audit, CQI projects) | Audit and inspection reports, CQC inspection reports, press coverage, etc. | I&E (2,4) | TBC |
| P,C | Enhance knowledge and awareness through Online and off-line trainings, e-learning, real-time IQPR and Patient safety framework, fill rate reporting to the Executive Team and Board. | Dashboards, reports and staff eLearning data | I (2&3) | TBC |
| P,C | Effective Ward based Risk Register and methodology (incorporating clinical risk) | Reduction in risk levels and reduction in associated incidents | I (1,2,3) | TBC |
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| Risk Title 7/25 | 2 – Quality of Services | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

| Gaps in control or assurance | | | |
|---|---|---|---|
| Gaps in controls | | Gaps in assurance | |
| C1 | To be documented | A1 | To be documented |
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| Actions (what can we do to fill these gaps?) | | | | |
|---|---|---|---|---|
| Gap | Action description | Action owner | Status update | Deadline |
| A1 | To be documented | | | |
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| Risk Title | 3 – Financial Objectives | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to achieve agreed financial objectives, control direct costs, together with lower than expected bed occupancy, will result in potential challenges for financial sustainability (including cash flow and bank credit facility) of the Charity questioning its going concern. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Likely (4) x Catastrophic (5) = 20 | | | | | | |
| Exec Lead | Chief Finance Officer | Oversight Committee | Finance & Performance Committee | Current score | Possible (3)x Major (4) = 12 | | | | | | |
| Datix material risk ref(s) | 908, 1021 | Risk App. Category | Financial Sustainability | Risk Appetite | Moderate (12) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Adequate | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P,C | Committee oversight of financial performance (Finance and Performance Committee, Finance & Contracts Group, SPOG, Executive Meetings, etc.). Ongoing risk assessments | Committee minutes and action plans (Note: “E” represent the external bodies for assurance including the Banks, NHSI, External Auditors, etc.) | I,E (2,3,5) | TBC |
| P,C | Ongoing rolling 3-month risk assessment reviewed weekly at the Exec Meetings (Action, Control and Mitigations, implemented as appropriate). | | I,E (1,2,3) | TBC |
| P | Oversight through individual and collaborative reviews (Daily staffing establishment, Occupancy reporting, Budget reviews, Performance reviews, Staffing performance review, daily occupancy reporting) | Dashboards and reporting | I,E (1,2,3) | TBC |
| P | Reporting (performance at Ward / division level, staffing levels, budget achievements, financials ward to board levels) P - Forward look at occupancy, staffing | Dashboards and reporting | I (1,2,3) | TBC |
| P,C | Bi-weekly cash flow forecasting for immediate cash flow, Long-term cash flow forecast part of financial performance oversight. | Reporting, re-forecasting, bank covenants | I (3,5) | TBC |
| C | Cost improvement programme | Actual vs. Budget reporting will enable us to monitor and report the short term cost-improvement initiatives, the medium-term cost-improvement program would be monitored via FinCom | I (2,3,5) | TBC |
| P | Annual Budgetary control process, coupled with twice / half-yearly re-forecast programme. | Monthly P&Ls and financial reports | I (1,2,3,5) | TBC |
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| Risk Title 7/25 | 3 – Financial Objectives | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

| Gaps in control or assurance | | | |
|---|---|---|---|
| Gaps in controls | | Gaps in assurance | |
| C1 | To be documented | A1 | To be documented |
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**Actions (what can we do to fill these gaps?)**

| Gap | Action description | Action owner | Status update | Deadline |
|---|---|---|---|---|
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| Risk Title | 4 – Workforce | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to attract, recruit and retain the right number of qualified and skilled staff will increase the likelihood of one or more of the following implications: Unsafe staffing levels across some or all services, Breach of regulatory / contractual requirements, Avoidable and undue pressure on existing staff affecting their morale, Reduced health and wellbeing, Reputational damage, etc. all of which have the potential to impact the quality and safety of patient care and the delivery of strategic business plans. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Likely (4) x Catastrophic (5) = 20 | | | | | | |
| Exec Lead | Exec HR Director | Responsible Committee | People Committee | Current score | Possible (3)x Major (4) = 12 | | | | | | |
| Datix material risk ref(s) | 914, 915, 996 | Risk Appetite Category | Workforce | Risk Appetite | Moderate (12) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Partial | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P | People & Organisational Development Plan and associated guiding principles | Committee Progress Report, CQC feedback, and Associated performance measures and tracking | I,E (2,3,5) | TBC |
| P,C | People Scorecards including Vacancy, Turnover, and Recruitment reporting, Absence, etc. | Integrated dashboard and triangulation with associated dashboards | I (2,3) | TBC |
| P | Lead the Change programme ( Discovery, Design, Implementation – Co-produced by Change Leaders) | Reports, Action plans, Status updates, Staff survey (Your Voice), CQC feedback, etc. | I,E (3,5) | TBC |
| P,C | Open Culture Activities - encouraging staff to speak up (Speak-up Policy, Employee Forum, 'Your Voice', Whistle-blowing external hotline, BENS Patient Recovery Forum, Speaking Up Guardians, Patient and Carer Activities, Lead the Change – Change Leaders). | Reports, Action plans, Status updates, Staff survey (Your Voice), CQC feedback, etc. | I,E (1,2,3) | TBC |
| P,C | Employee wellbeing programmes – “In-house” occupational health service, Specialist Trauma Counsellor, Employee Assistance Programme, compassion focused staff support programme | Take-up of programmes and Staff Survey. | I (1,3,5) | TBC |
| P | Automation programmes including the introduction of MHOST and Allocate (e-rostering initiative) | Safer staffing reports, dashboards, BI, etc. | I (3) | TBC |
| P | Retention focussed recognition programmes such as Apprenticeships, ASPIRE, Top-50, etc. | Retention, turnover and vacancy reports | I (3,5) | TBC |
| P | Recruitment initiatives and plans (International recruitment, Pipelines, Networks, etc.) | PeopleCom reports, Recruitment dashboards / Reports, Action plans, Status updates, | I (1,2,3) | TBC |
| P,C | Workforce planning and New roles development | Dashboards, Metrics, KPIs, forecasts, etc. | I (1,2,3) | TBC |
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| Risk Title | 4 – Workforce | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

**Gaps in control or assurance**

| Gaps in controls | | Gaps in assurance | |
|---|---|---|---|
| C1 | People & Organisational Development Plan and associated guiding principles | A1 | To be documented |
| C2 | Automation programmes including the introduction of MHOST and Allocate (e-rostering initiative) | A2 | |
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**Actions (what can we do to fill these gaps?)**

| Gap | Action description | Action owner | Status update | Deadline |
|---|---|---|---|---|
| A1 | To be documented | | | |
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| Risk Title | 5 – Organisational culture | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to foster a "Charity-wide" culture derived from our CARE values which is positive and challenging, and promotes openness, transparency, diversity, inclusion, and ethical behaviour and drives a quality first ethos, will result in a disjointed and fragmented approach to delivery of strategic business plans and achievement of Charity-wide objectives. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Likely (4) x Major (4) = 16 | | | | | | |
| Exec Lead | CEO | Responsible Committee | People Committee | Current score | Possible (3)x Major (4) = 12 | | | | | | |
| Datix material risk ref(s) | 916 | Risk Appetite Category | Workforce | Risk Appetite | Moderate (12) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Adequate | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P,C | Open Culture Activities - encouraging staff to speak up (Speak-up Policy, Employee Forum, 'Your Voice', Whistle-blowing external hotline, BENS Patient Recovery Forum, Speaking Up Guardians, Patient and Carer Activities, Lead the Change – Change Leaders). | Reports, Action plans, Status updates, Staff survey (Your Voice), CQC feedback, etc. | I,E (1,2,3) | TBC |
| P | Lead the Change programme ( Discovery, Design, Implementation – Co-produced by Change Leaders) | Reports, Action plans, Status updates, Staff survey (Your Voice), CQC feedback, etc. | I,E (3,5) | TBC |
| P,C | Employee wellbeing programmes – "In-house" occupational health service, Specialist Trauma Counsellor, Employee Assistance Programme, compassion focused staff support programme | Take-up of programmes and Staff Survey. | I (1,3,5) | TBC |
| C | 'Your Voice' Survey | Your Voice Survey reports | I (1,2,3,5) | TBC |
| P,C | Charity-wide People and Organisational Development Plan | Associated performance measures and tracking | I (2,3) | TBC |
| P,C | Charity-wide Diversity & Inclusion Plan (Annual D&I report) | Associated performance measures and tracking | I (2,3) | TBC |
| P,C | Charity-wide culture survey through external service provider | Survey results – Action plan | I (2,3) | TBC |
| P | Retention focussed recognition programmes such as Apprenticeships, ASPIRE, Top-50, etc. | Retention, turnover and vacancy reports | I (3,5) | TBC |
| P | Clear organisational structure | Updated Organisation structure as per Board Pack. | I (3,5) | TBC |
| P | Automation programmes including the introduction of MHOST and Allocate (e-rostering initiative) | Safer staffing reports, dashboards, BI, etc. | I (3) | TBC |
| P,C | Staff Networks - ABLE, BAME, PRIDE, WiSH, Employee Forum. | Internal reports on network events | I (2,3,5) | TBC |
| P,C | People Scorecards including Vacancy, Turnover, and Recruitment reporting, Absence, etc. | Integrated dashboard and triangulation with associated dashboards | I (2,3) | TBC |
| C | Learning & Development programmes | Evidence of training completion | I (1,3) | TBC |

| Risk Title 7/25 | 5 – Organisational culture | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

**Gaps in control or assurance**

| Gaps in controls | | Gaps in assurance | |
|---|---|---|---|
| C1 | Employee wellbeing programmes – “In-house” occupational health service, Specialist Trauma Counsellor, Employee Assistance Programme, compassion focused staff support programme | A1 | To be documented |
| C2 | Clear organisational structure | | |
| C3 | Automation programmes including the introduction of MHOST and Allocate (e-rostering initiative) | | |
| C4 | Learning & Development programmes | | |
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**Actions (what can we do to fill these gaps?)**

| Gap | Action description | Action owner | Status update | Deadline |
|---|---|---|---|---|
| A1 | To be documented | | | |
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| Risk Title 7/25 | 6 – Partnership Working | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to identify and adapt to changing environment, and work closely with external partnerships to improve the delivery of patient care and/or seek new services will increase the likelihood of one or more of the following (i) Inability to solve genuine customer challenges. (ii) Inability to be prominent at both a local and national level. (iii) Reduced relevance with regards to strategic and operational agility. (iv) Reduced ability to be collaborative through strategic alliances in offering contemporary care programmes; eventually leading to erosion of market share, patient base, loss of charitable agency, etc. ultimately leading to potential loss of long-term sustainability. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Almost Certain (5) x Major (4) = 20 | | | | | | |
| Exec Lead | CEO | Responsible Committee | Finance & Performance Committee | Current score | Possible (3)x Major (4) = 12 | | | | | | |
| Datix material risk ref(s) | 921, 924 | Risk Appetite Category | Partnerships | Risk Appetite | High (15) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Partial | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P,C | Establish strong relationships with commissioners, regulators, regional and national team | Output of meetings, positive reports, references relating to new business, increased referrals | E (5) | TBC |
| P | Delivery of quality service and compliance with contractual requirements | Self-assurance on compliance and completion (and output) of internal and external audits | I,E (2,4,5) | TBC |
| P | Provider Collaboration Partnerships (Memorandums of Understanding) | High levels of service user utilisation within the collaborative area, signed MOUs | I,E (3,5) | TBC |
| P | Increased Senior Leadership presence at all key ICS meetings | Key contributor in wider system discussions and processes | I,E (3,5) | TBC |
| P | Strategic Partnership Team – customer and stakeholder engagement | Increased partnerships, continued movement of one-off customers to continued offerings, increase in involvement within Provider Collaboratives | I,E (1,3,5) | TBC |
| P,C | Successful embedding and maintenance of NHFT Buddy System | Workstream reports, continued engagement and involvement in alliance activities | I,E (3,5) | TBC |
| P | Partnership and Promotion element of Charity Strategy | Achievement of milestones and objectives | I (2,3,5) | TBC |
| P,C | Strategic Market Insight process and gathering of relevant and useable intelligence | Periodic reports and applicable actions | I (2,3) | TBC |
| P,C | Exec Director Relationship Programme : Established programme to manage third party relationships where relevant to the Charity's Strategy | Feedback and updates from networking events and contact meetings | I (3,5) | TBC |
| | | | | |

| Risk Title 7/25 | 6 – Partnership Working | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

| Gaps in control or assurance | | | |
|---|---|---|---|
| Gaps in controls | | Gaps in assurance | |
| C1 | Development of strategic alliance plan still to be completed | A1 | To be documented |
| C2 | Stakeholder mapping to ensure we are supporting right partners including key ICS | A2 | |
| C3 | Confirmation of Exec Director Relationship Programme is in place with understanding of relationships, meeting frequency and expected outputs | | |
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| Actions (what can we do to fill these gaps?) | | | | |
|---|---|---|---|---|
| Gap | Action description | Action owner | Status update | Deadline |
| A1 | To be documented | | | |
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| Risk Title | 7 – Strategic Asset and Estate Management | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to acquire and maintain "right-sized" and "fit for purpose" strategic assets; coupled with ineffective management of the estate will result in (i) the inability to expand on the strategic aim relating to provision and fulfilment of community based beds, (ii) higher cost of maintenance impacting financial sustainability, (iii) potential breach of regulations, and (iv) reputational damage. All of which collectively will impede the Charity in achieving its strategic objectives. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Likely (4)x Major (4) = 16 | | | | | | |
| Exec Lead | Director of Estates & Facilities | Responsible Committee | Finance & Performance Committee | Current score | Possible (3)x Major (4) = 12 | | | | | | |
| Datix material risk ref(s) | 924, 909 | Risk Appetite Category | Performance and service sustainability | Risk Appetite | Moderate (12) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Partial | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P | Partnership and promotion strategic strand | SMT and delivery of implementation plans | I (2,3) | TBC |
| P | Detailed investment plan (facet plan) | Estate strategy supported by cost and maintenance program | I (2,3) | TBC |
| P,C | Clear defined asset and estate disposal process (an aligned buy/sell/hold strategy) | Internal audit and Finance and Contracts reviews | I (3) | TBC |
| P,C | Effective maintenance program to address the backlog in maintenance and compliance risk | Compliance reviews, Internal audits, External inspections (HSE and Fire Standards). | I,E (3,5) | TBC |
| P | Clear Asset management policy (ROI, Capital and Revenue Expenditure Procedure, Depreciation) | Internal performance reviews | I (2,3) | TBC |
| P | Fully aligned estate strategy with Charity strategy 2022-27 | Updated and approved strategy and internal reviews | I (2,3) | TBC |
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| Risk Title 7/25 | 7 – Strategic Asset and Estate Management | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

| Gaps in control or assurance | | | |
|---|---|---|---|
| Gaps in controls | | Gaps in assurance | |
| C1 | Fully aligned estate strategy with Charity strategy 2022-27 | A1 | To be documented |
| C2 | Partnership and promotion strategic strand | | |
| C3 | Detailed investment plan, facet plan | | |
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| Actions (what can we do to fill these gaps?) | | | | |
|---|---|---|---|---|
| **Gap** | **Action description** | **Action owner** | **Status update** | **Deadline** |
| A1 | To be documented | | | |
| A2 | | | | |
| A3 | | | | |
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| Risk Title | 8 – Service Innovation | | | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Description | Failure to innovate and offer effective service offerings, newer ways to improve the delivery of patient care will increase the likelihood of one or more of the following, (i) Perceived as archaic service provider, (ii) Being irrelevant with regards to the service offering, the care model, etc. (iii) Being reactive as against being proactive; leading to potential impeding long-term sustainability. | | | Risk rating (impact x likelihood) | | To be Determined<br>Run Chart for Residual risk versus Risk Appetite | | | | | |
| | | | | Initial score | Almost Certain (5)x Major (4) = 20 | | | | | | |
| Exec Lead | EMD | Responsible Committee | Quality & Safety Committee | Current score | Likely (4)x Major (4) = 16 | | | | | | |
| Datix material risk ref(s) | 904, 911, 921, 924 | Risk Appetite Category | Research & Development | Risk Appetite | High (15) | | | | | | |

| Assurance rating (Rolling by Board meeting) | July 2022 | September 2022 | November 2022 | January 2022 | March 2023 | May 2023 |
|---|---|---|---|---|---|---|
| | Limited | | | | | |

| Key controls / mitigations in place | | Assurance that controls are effective | | Date |
|---|---|---|---|---|
| *The main controls/systems in place to manage principal risks & to reduce the likelihood and impact of the risks* | | *Sources of assurance that demonstrate the controls are effective, both Internal & External (with the stated line of assurance provided)* | | *Date of last assurance* |
| P | Service Innovation Implementation Framework (Guidelines and documented procedures for new services and innovative therapies) | Approved framework for innovation and adherence to guidelines. Periodic reviews of new services and therapies versus agreed framework and targets | I (3,4,5) | TBC |
| P | Service Innovation function to oversee the implementation of innovation and new services | Fully established function and successful implementation and embedding of new services or service enhancement to existing services | I (3) | TBC |
| P | Business Development team | Fully established function and successful development of new opportunities | I (3) | TBC |
| P,C | Therapies Advisory Group – Oversight of therapies and their impact, along with appropriate horizon scanning to look at new innovative therapies which may be incorporated | Committee minutes and action plans, results of deep dives and focussed reviews | I (2) | TBC |
| P | Specific oversight of Finance & Performance Committee on the commercial aspects and implications of new and innovative services | Committee minutes and action plans, results of deep dives and focussed reviews | I (2,5) | TBC |
| P | Management of therapeutic risks within existing risk frameworks and appetite process | Risk reviews and deep dives and risks maintained within agreed targets and appetite. Level of reportable incidents as a result of new therapies or services are within agreed targets and benchmarked KPIs. | I & E (1, 2, 3, 5) | TBC |
| | | | | |
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| Risk Title | 8 – Service Innovation | Strategic priority | Quality | Service Innovation | Research & Innovation | Education & Training | Partnerships & Promotion | Finance & Sustainability | Workforce Resilience & Agility |
|---|---|---|---|---|---|---|---|---|---|

**Gaps in control or assurance**

| Gaps in controls | | Gaps in assurance | |
|---|---|---|---|
| C1 | Innovation implementation framework (Guidelines and documented procedures for new services and innovative therapies) | A1 | To be documented |
| C2 | Service innovation function to oversee the implementation of innovation | A2 | |
| C3 | Business Development team (in place, but remains in its infancy) | | |
| C4 | Therapies advisory group – Horizon scanning process and resultant actions/recommendations in relation to new innovative therapies which may be incorporated | | |
| C5 | Specific oversight of Finance & Performance Committee on the commercial aspects and implications of new and innovative services – revised ToR required and oversight to be implemented | | |
| C6 | Management of therapeutic risks within existing risk frameworks and appetite process – new appetite methodology to be implemented and embedded. | | |

**Actions (what can we do to fill these gaps?)**

| Gap | Action description | Action owner | Status update | Deadline |
|---|---|---|---|---|
| A1 | To be documented | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

# Risk Scoring Matrix, Assurance Ratings and Risk Appetites

| Likelihood | Impact: Insignificant | Minor | Moderate | Major | Catastrophic |
|---|---|---|---|---|---|
| Almost Certain | 05 | 10 | 15 | 20 | 25 |
| Likely | 04 | 08 | 12 | 16 | 20 |
| Possible | 03 | 06 | 09 | 12 | 15 |
| Unlikely | 02 | 04 | 06 | 08 | 10 |
| Rare | 01 | 02 | 03 | 04 | 05 |

| Risk Domain / Category | Risk Appetite Level | Extent of Risk Appetite | Risk Tolerance | Risk Management Approach | Residual Risk for Escalation |
|---|---|---|---|---|---|
| Quality | 1 – Minimal | Low Appetite | Low Tolerance | Cautious | 12 or more |
| Safety | 1 – Minimal | Low Appetite | Low Tolerance | Cautious | 12 or more |
| Regulatory / Compliance | 2 – Cautious | Moderate Appetite | Moderate tolerance | Conservative | 12 or more |
| Research and Development | 3 – Open | High Appetite | High Tolerance | Confident | 15 or more |
| Reputation | 2 – Cautious | Moderate Appetite | Moderate Tolerance | Conservative | 12 or more |
| Performance and service sustainability | 2 – Cautious | Moderate Appetite | Moderate Tolerance | Conservative | 12 or more |
| Financial Sustainability | 2 – Cautious | Moderate Appetite | Moderate Tolerance | Conservative | 12 or more |
| Workforce | 2 – Cautious | Moderate Appetite | Moderate Tolerance | Conservative | 12 or more |
| Partnerships | 3 – Open | High Appetite | High Tolerance | Confident | 15 or more |

| Risk Rating | Action Required |
|---|---|
| Low (1-3) | Monitoring of risk, further risk reduction may not be feasible or cost effective, refer to risk appetite |
| Moderate (4-6) | Risk reduction required so far as is reasonably practicable, refer to risk Appetite |
| High (8-12) | Action required so far as is reasonably practicable, refer to risk Appetite |
| Major (12-25) | Immediate action required so far as is reasonably practicable, refer to risk appetite |

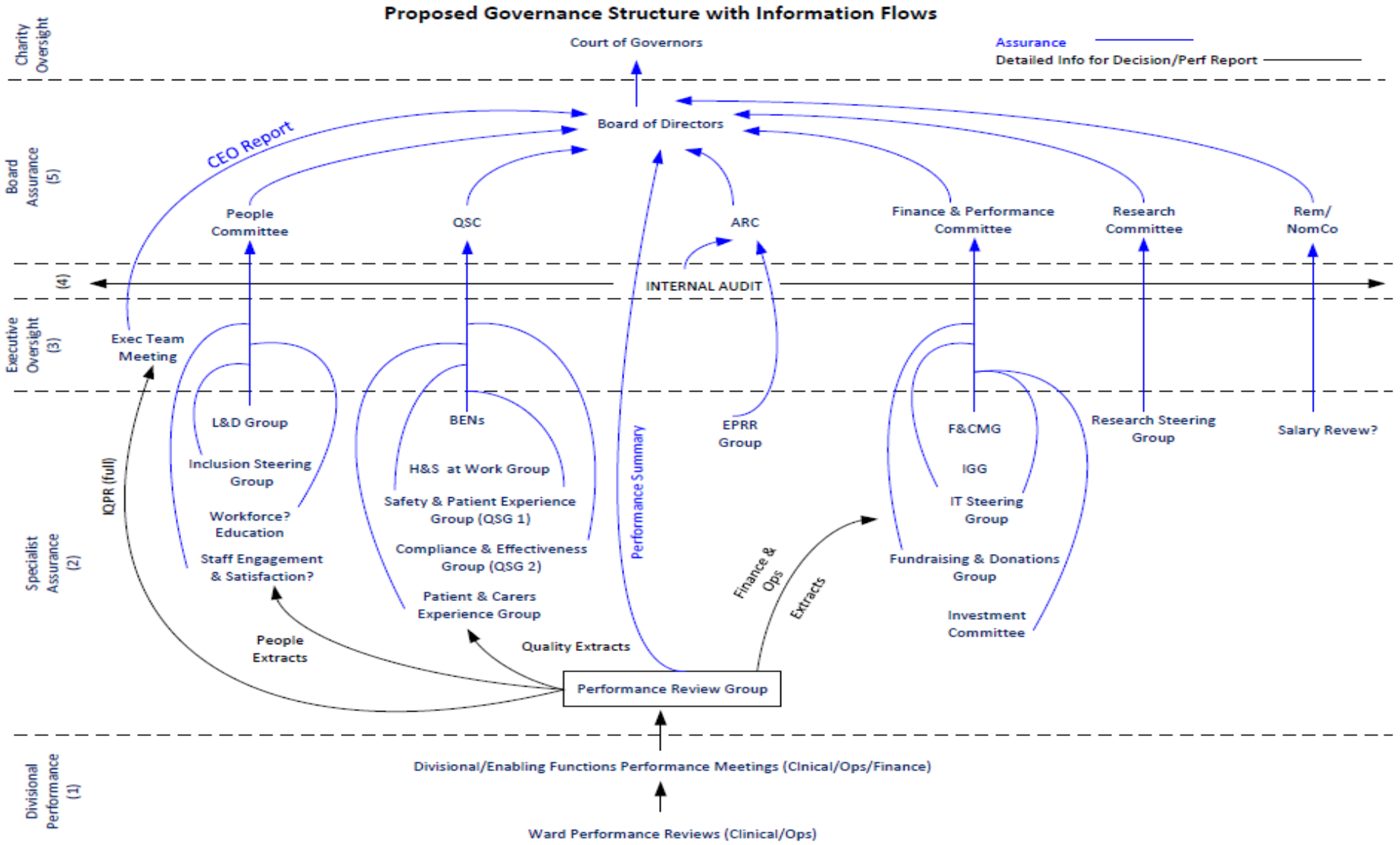
| Assurance Level | Description |
|---|---|
| Substantial | There is substantial level of control over the key risks. The tested controls have been applied consistently and effectively. No significant improvements are required. |
| Adequate | Key risks are covered by adequate levels of control. Although there are some weaknesses in the application of control procedures, the weaknesses are not sufficiently critical to compromise the system of internal control. Some improvements are recommended to enhance existing controls. |
| Partial | Some key risks have inadequate levels of control or key controls are not being consistently applied. The weaknesses identified, taken together or individually, impair the system of internal control. Prompt corrective action is required by management to significantly improve the application of key controls. |
| Limited | Key risks are generally not covered by adequate levels of control. A widespread lack of application of key controls undermines the system of internal control. This failure of the control infrastructure has had, or is likely to have, significant implications for the business. Urgent management attention is recommended to implement effective controls. |

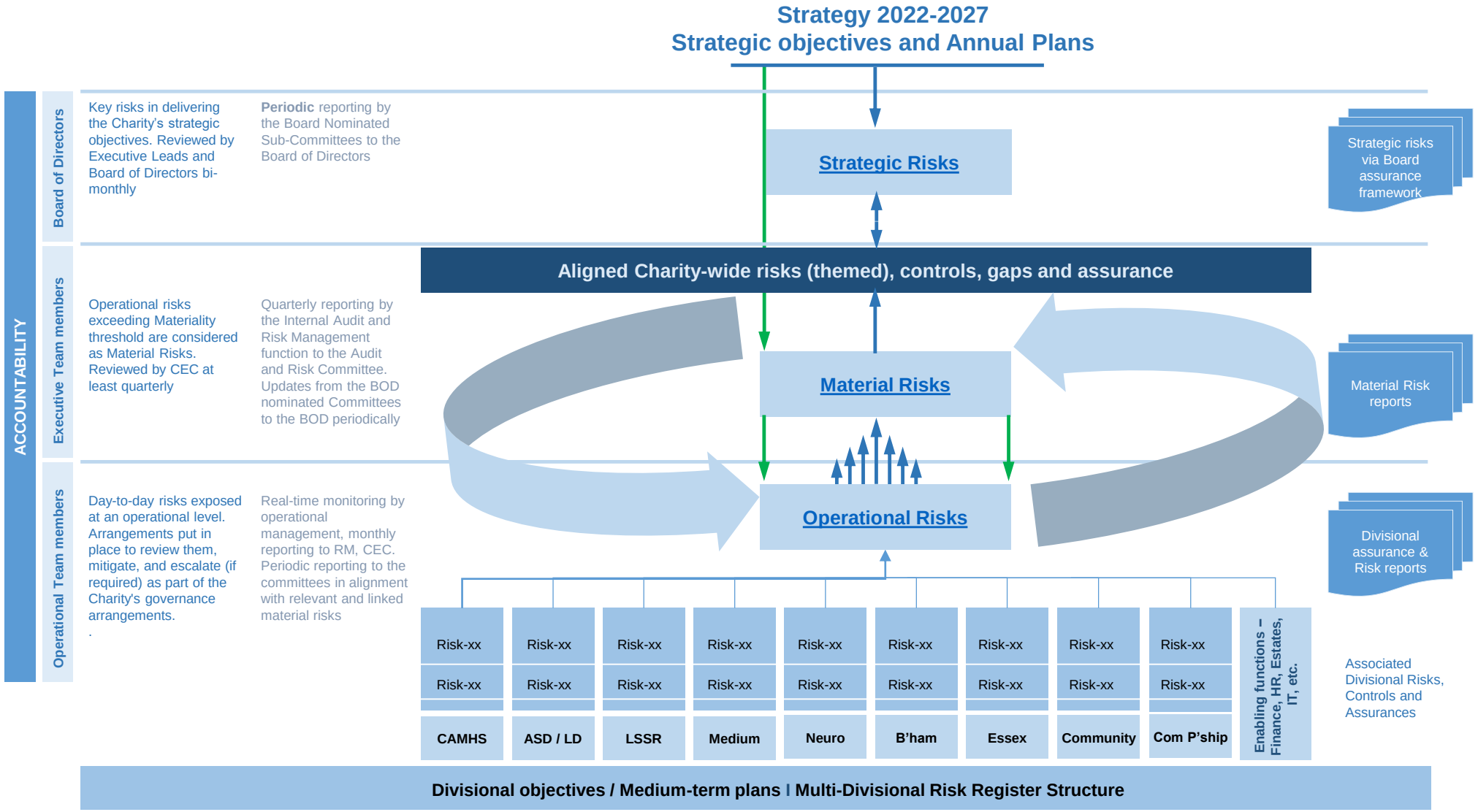
# Proposed Governance Structure with Information Flows

**This model has been proposed by leading Risk Management professionals as an evolution of the 3 Lines of Defence model to elevate the role of the Board and other key executive stakeholders such as the CEO in risk governance.**

The structure is broken down as follows:

1. 1st Line – Work Units / Divisions - Divisional leaders with assigned ownership or responsibility for reporting on specific risks, and ensuring resources are protected and objectives are being achieved.
2. 2nd Line – Specialist Units - Specialist units providing expertise on specific types of risk, such as treasury, safety, environment, legal and insurance with responsibility for related risk management processes.
3. 3rd Line – CEO / C-Suite - Senior executives and senior managers with overall responsibility for building and maintaining a robust risk management process and delivering reliable information on the principal risks.
4. 4th Line - Internal audit activities, providing independent and timely information to the board on reliability of the risk management processes in the organisation and producing consolidated reports.
5. 5th Line – Board of Directors -The board of directors with overall responsibility for ensuring that effective risk management processes are in place and the other lines are managing risk.




Strategy 2022-2027
Strategic objectives and Annual Plans
ACCOUNTABILITY
Board of Directors
Executive Team members
Operational Team members
Key risks in delivering the Charity's strategic objectives. Reviewed by Executive Leads and Board of Directors bi-monthly
Periodic reporting by the Board Nominated Sub-Committees to the Board of Directors
Operational risks exceeding Materiality threshold are considered as Material Risks. Reviewed by CEC at least quarterly
Quarterly reporting by the Internal Audit and Risk Management function to the Audit and Risk Committee. Updates from the BOD nominated Committees to the BOD periodically
Day-to-day risks exposed at an operational level. Arrangements put in place to review them, mitigate, and escalate (if required) as part of the Charity's governance arrangements.
.
Real-time monitoring by operational management, monthly reporting to RM, CEC. Periodic reporting to the committees in alignment with relevant and linked material risks
Strategic Risks
Aligned Charity-wide risks (themed), controls, gaps and assurance
Material Risks
Operational Risks
Strategic risks via Board assurance framework
Material Risk reports
Divisional assurance & Risk reports
Risk-xx
CAMHS
ASD / LD
LSSR
Medium
Neuro
B'ham
Essex
Community
Com P'ship
Enabling functions – Finance, HR, Estates, IT, etc.
Associated Divisional Risks, Controls and Assurances
Divisional objectives / Medium-term plans I Multi-Divisional Risk Register Structure

# Strategic Risks

## 2 Explanation:

1. Through BAF, the Charity obtains an assurance over whether key risks that could prevent the delivery of the strategic objectives are being effectively managed.
2. Strategic risks will be scored using an agreed methodology in line with the Charity's Risk Management Policy and Procedure.
3. The Audit and Risk Committee (ARC) will review whether the format of the BAF and the way it is drawn up and used (in particular its maintenance and updating) are 'fit for purpose'. The ARC may achieve this by commissioning an annual review of the BAF from internal audit (frequency to be determined).
4. Board Committees will review assigned Strategic Risks within the BAF on a regular basis, including oversight of remediation of gaps in controls / assurance that threaten the delivery of the strategic objectives (i.e. by strengthening internal controls, or commissioning internal audits to provide assurance over the internal controls / functions that are critical to the achievement of individual strategic objectives).
5. Executive Leads for Strategic risks review risks on a bi-monthly basis with Internal Audit & Risk Manager and CoSec. IARM and CoSec to compile the BAF ahead of reporting to Board.
6. The Board will review the BAF on a bi-monthly basis and will 'confirm and challenge' the overall assurance rating for each BAF risk as part of this review
7. The Charity's Strategy will be reviewed and updated on an annual basis to ensure that it remains appropriate, with the BAF updated to reflect any changes.

## Definition:

**Strategic Risk** includes such risks which are inherent risk to the delivery of the organisation's strategic objectives, that should not change significantly over time.

1

**Strategic Risks**

## 3 Relationship with Material Risks and Operational Risks:

1. The Strategic risks maintain a relation with the Operational risks as well as with Material risks, from an upstream approach, as Strategic risks will require controls to be designed at operational levels. All operational tasks undertaken have a relationship to the overall strategy; whether at a functional strategy, divisional strategy, or overall business strategy level. Hence, there exists a direct relation of the success of operational tasks or otherwise, on the overall impact to the strategic objective.
2. Strategic risks may be bifurcated into many operational risks (which upon reaching the threshold limit, may then be categorised as Material risks). One or more of such derived operational risks may exceed the threshold, thereby qualifying to be captured as Material risks. This may only be for a specific period of time, whilst the Material risk is being managed and mitigated.

4

| | BoD | BoD Nominated sub-comm | Risk owners (Exec Members) | CoSec. Team |
|---|---|---|---|---|
| Tone at the Top | A&R | S | S | NA |
| Risk Identification | A&R | C | C&I | S&C |
| Risk Assessment | A&R | C | C | S&C |
| Risk Treatment | A&R | C | C | S&C |
| Risk Monitoring & Review | A&R | S | S | S |
| Risk Recording | I | I | A | R |
| Risk Reporting | I | I | A | R |
| Process establishment | A&R | I | A | R |

Legend:

1. R - Responsible: The team member(s) doing the actual work to complete the task.
2. A - Accountable: This person delegates work and is the last one to review the task or deliverable before it's deemed complete. Being Accountable means you must answer for and/or sign off on the deliverable and deal with the consequences if it falls short of goals.
3. C - Consulted: Consulted parties are typically the people who provide input based on either how it will impact their future project work or their domain of expertise on the deliverable itself.
4. S - Support : Supportive' members may provide help by providing resources to the Responsible members. They actively work with the Responsible in order to carry the project to completion. Both Supportive and Responsible members have the same goals.
5. I - Informed: These members need to be informed on major developments, rather than roped into the details of every deliverable.

**Appendix 2 – SMT and Executive Summary – 13 July 2022**

| Paper for Executive Meeting | |
|---|---|
| **Topic** | Charity Strategy Progress Update |
| **Date of Meeting** | 13th July 2022 |
| **Agenda Item** | **12** |
| **Author** | Eddie Short, Director of Strategy |
| **Responsible Executive** | Oliver Shanley, Interim Chief Executive Officer |
| **Discussed at Previous Exec Meeting** | Update discussed at Strategy Executive Team Meeting monthly |
| **Patient and Carer Involvement** | Involved through the detailed delivery plans |
| **Staff Involvement** | Involved through the detailed delivery plans |
| **Report Purpose** | Review and comment ☒<br>Information ☐<br>Decision or Approval ☐ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☒ **C** ☐ **R** ☐ **W** ☒ |
| **Strategic Focus Area** | Quality ☒<br>Service Innovation ☒<br>Research and Innovation ☒<br>Finance and Sustainability ☒<br>Education and Training ☒<br>Workforce Resilience and Agility ☒<br>Partnerships and Promotion ☒ |
| **Committee meetings where this item has been considered** | Full strategy progress update has not been discussed at any committee meetings |

**Report Summary and Key Points to Note**

This report provides an update on activity and progress in pursuit of our 2022-27 strategic objectives, with a focus on the milestones agreed for each of the seven priority areas.

Of the 17 milestones due in quarter 1 2022/23, 13 have been achieved. The milestones that have not been achieved are:

- *Domain name change to .org*. Resources were deployed against higher level priorities during the period, slowing the progress of this change, which will now be enacted in mid-August

- *Establish Business Development Team by Q2*. Recruitment to the Business Development Team was impacted by an unsuccessful first recruitment round however appointments have been made and the team are now in post and will have concluded their induction by then end of July.

The delay in recruiting will have an impact on the subsequent milestones of completing a broad options analysis and outline of opportunities ahead of a gateway review and approval at the September Board. This review will be deferred until the November Board.

- *Establish an enlarged and combined 'research and education hub' in the historic Northampton hospital building with input from our academic and industry partnerships:* achievement of this milestone has been impacted by the absence of operational leadership and organisational clarity around the underpinning architecture and structure for our research and education ambitions. Our intent is to resolve this through Q2/3 2022/23 and reschedule delivery of the milestone for Q4 2022/23. This will have an impact on the milestone associated with the investment in Research and Innovation but is not expected to adversely affect other plans.

- *Deliver "thank you gift" / Wellbeing Hampers to all staff.* This milestone was not progressed following early feedback from the Change Leaders and we are exploring alternative options for saying 'thank you' to our staff.

The report provides a narrative for activity and progress for each priority area. Much of the work in this first period has been focussed on the enabling elements of the strategy (quality, workforce, resilience & agility, finance & sustainability) seeking to establish stability within these critical areas of focus.

Across the other priority areas, much of the work has also been putting in place the foundations that will enable the Charity to pursue the value creating elements of the strategic ambitions. However, there have been developments in respect of an increase in the services being delivered by our Community Partnerships Team and in the volume of medical students we host, bringing a modest increase to our income.

Strategy adoption across the Charity is key to successfully achieving our overall objectives. The changes that are required will occur through harnessing the actions, ideas, knowledge and experience of everyone to inform the 'how' we will achieve our ambitions. We have delivered sessions to the Senior Leadership Team and our Lead the Change champions to provide the opportunity for developing greater understanding of the 'what and why' and engaging these leaders with the 'how'. The feedback has been that we need to make the language and presentation of the strategy more accessible and motivating and we are currently working with a group of Lead the Change champions to do this. Alongside this we are working with leaders through the Charity to enable them to work with their teams and the people they directly and indirectly influence to further cascade understanding and activate excitement, engagement and adoption of the strategic ambitions.

In pursuit of the goals of strategy adoption and increasing the activity we are undertaking that will progress us towards our objectives, we have established an annual planning approach that engages all Divisions and Enabling Functions in identifying how they can further contribute, whilst aligning with their individual priorities and interests. This approach will see focussed local plans produced that will aggregate to support the priority area objectives, with quarterly reviews and a timetable aligned to the budget planning cycle.

The Executive Team have discussed the need for a suite of measures that will demonstrate progress towards the strategic objectives and priority area sub objectives, that will sit alongside the tracking of milestone delivery. Existing measures are likely to be viable for some areas (e.g. quality) whereas we will need to develop approaches for others (e.g. brand recognition). Establishing these measures is a work in progress and will evolve and iterate over the lifecycle of the strategy, however we will begin to establish and report on these in the coming period.

The Executive Team are asked to review and comment on this update and are encouraged to offer a 'check and challenge' to SRO colleagues to ensure we are delivering on our ambitious plans.

**Appendices –** Appendix 1 Strategy Milestone Tracker

# Strategy Progress Update

The Charity Strategy was approved by the Board in March 2022 and sets an ambitious agenda for transformation over the next 5 years. The strategic objectives are being delivered through seven priority areas with four of these being enablers of the ambitions and the remaining three being the 'value creators' – for the Charity, stakeholders and society more broadly.

Recognising the ambitious nature of our strategy a phasing of the focus for each priority area over the 5 year lifespan has been set in order that we do not overwhelm our capacity to deliver. The Charity's primary focus for 22/23 is on delivering against the plans for:

- Quality
- Finance & Sustainability
- Workforce Resilience & Agility

Updates against each priority area are set out below, with the assessment of progress against the agreed objectives and milestones set out in the Strategy Milestone Tracker at appendix 1.

## Quality

No milestones were scheduled for delivery in this quarter, instead the activity undertaken – as detailed below - has been in aid of building elements of the required structural, behavioural and cultural elements that achievement of our objectives will be built on.

This work has occurred in parallel with the ongoing reactive work to stabilise and improve quality in those areas where we have received poor CQC ratings or have identified concerns. Despite this, we do not perceive any future slippage in relation to the milestones as previously set out.

<u>Quality Care that is fit for the future</u>
Working collaboratively with through the 'buddy' quality workstreams and the Quality Improvement Director we have put in place both a Charity-wide Quality Improvement Plan (QIP) and ensured that every ward has its own QIP, enabling both local action and accountability in ward specific areas of challenge and an overarching focus.

We are pursuing technology enabled solutions to improve safety, efficiency and effectiveness with specific projects focussed on Electronic Observations (e-obs) and Body worn cameras. Initial results from both projects are indicating positive impacts with e-obs enabling 'in the moment' flagging of whether a required patient observation has been made alongside automated record keeping. In addition to these developments we are also considering the Oxe Health system that provides remote monitoring of a person's vital signs enabling a least restrictive observation intervention.

Workforce developments include the continuation and expansion of the Ascend & Aspire programmes as well as work that is exploring roles & responsibilities within clinical areas to ensure appropriate and creative division of tasks to safely but efficiently meet the clinical need of patients.

We are working on the development of quality leading indicator metrics to support oversight and improvement work, however the progression of this work is constrained by resource capacity issues within IM&T teams who are currently deployed on higher priority activities.

We have produced and are in the process of approving the Physical Healthcare strategy and in parallel have developed and implemented the physical healthcare dashboard. Physical healthcare training including NEWS2 and neurological observations are being provided with the combination of all of these elements supporting a more robust physical healthcare offering to our patients.

Minimising patient harm and delivering safe care

Our Quality Strategy is in draft and due for initial review by the Executive Team in early July with the associated quality architecture also in development.

The patient safety implementation plan is in draft and we are awaiting the publication of a new national patient Safety Incident Response Framework (PSIRF) which has been delayed until July 2022. The patient safety framework, ward board and daily flash dashboards are all in place enabling contemporaneous oversight at a ward level.

We are recruiting to a Clinical Equipment Officer and Lead Resuscitation Officer posts providing capacity for oversight and leadership in these specific areas.

Delivering a great patient experience

We have co-produced our co-production strategy and this is due to be reviewed for approval via the People Committee in July. This strategy sets out our clear intentions in respect of working in partnership with patients, service users and carers in co-designing and co-delivery individual care and wider service developments.

We have introduced Your Voice to capture the patient experience that will help us to understand the overall experience and the detailed likes and dislikes at ward level. We are encouraging patient participation in providing this feedback and working with Divisional and ward level leaders to ensure that the value of the insights is understood, harnessed and acted upon.

## Finance & Sustainability

All five of the milestones scheduled for quarter 1 have been met. The primary focus during the period has been establishing mechanisms for firmer grip and control to achieve the budget alongside progressing the Revolving Credit Facility (RCF) renewal.

Additionally the following activity has been undertaken:

Budget Setting and Achievement

- Budgets for 2022/23 finalised and signed off by Board in March 2022
- Three key risks regularly monitored by Executive
    - Occupancy growth
    - Operating within the MHOST model/budget
    - Cost efficiency
- Occupancy continued to be behind budget for June 2022. Ongoing weekly reviews and monitoring in place
- Operating within the MHOST model budgeted cost base remains an area of concern. Action plans in place to mitigate risk.
- Cost efficiency plans - still on track to be achieved
- Full year forecast 22/23 completed and still expected to achieve the financial year budget net deficit position.

RCF Renewal

- Bank presentations concluded during May/June
- Progress on track with timetable
- Expecting bank lender confirmation – 11th July 2022. Outcome of this will determine next steps and timelines

Cost Improvement Program

- Charity Operating Model and three year cost management plan requested by Board.
- Scheduled finance lead priority to commence in full Qtr3 – although initial launch with IT Qtr2.

Asset Investment and Replenishment Program

- The process and policy has been incorporated into the annual budget cycle and is being maintained by the Finance and Contracts Group
- Continue to expand the areas covered and incorporate into the ongoing budgeting cycle and approach
- Provided control and assurance on maintaining the estate and IT asset portfolio but within financial constraints.

ESG

- The Director Development Program group are undertaking the preliminary assessment of what ESG represents for the Charity.
- This will be presented to Executive Team in August 2022
- ESG Strategy will continue to be developed thereafter

## Workforce Resilience & Agility

This priority area had one milestone due in Q1 2022/23: *Deliver "thank you gift" / Wellbeing Hampers to all staff.* This milestone was not progressed as early feedback from the Change Leaders has been that their priority would be to see a resolution to some of the basic needs issues they have identified (access to water, food at nights etc.). This feedback has been taken on board and work to progress those areas has commenced whilst we continue to explore options for saying 'thank you' to our staff. One such initiative that is in progress to be delivered in Q2 is offering the Blue Light Card for free to staff to support with Financial Wellbeing.

In the period we have developed the Wellbeing Plan which was taken to the Executive Team initial review. The Head of wellbeing has been working closely with Estates & Facilities on projects linked to the “Getting the basics right” element of the Wellbeing Plan:

- Discussions on the cost and implementation of water coolers on all wards has been completed, this is an area highlighted as a “quick win” by the Lead the change project
- Discussions completed with E&F and procurement on piloting offering sanitary products for staff in bathrooms. Details costings to be created in July and request for seed funding to be made for a pilot.
- Discussions with Retail manager on improving food provisions are ongoing

Additionally the following activity has been progressed:

- A compassion focussed Staff support roll out plan has been agreed. Further detail on which wards, when to be completed in July
- Menopause wellbeing information produced

- The first manager support documents have been created for "supporting staff wellbeing during absence" and "supporting staff in financial hardship"
- Wellbeing working group set up including Trauma support, Occupational Health, Speak up guardians, Carer's centre, D&I lead and REDS. This group will discuss wellbeing issues in the charity

Finally we have engaged in and / or delivered a number of wellbeing focussed events:

- Mental Health Awareness Week took place the week commencing Monday 9th May. As well as co-hosting Headfest, we had a series of events taking place at St Andrew's
- The annual STAH Care awards took place on the 30th of May
- Northamptonshire Virtual Wellbeing Festival promoted to staff first week of July.
- The staff party has been planned and will take place on 14th July

## Partnerships & Promotion

Eight out of the nine milestones scheduled for quarter 1 have been met. The outstanding milestone being *change of domain name to .org* that will provide a subtle additional signal through email communications of our charitable status. Resources were deployed against higher level priorities during the period, slowing the progress of this change, which will now be enacted in mid-August

Reputation

We had previously commissioned Research by Design (RbD) to establish an independent view of how external stakeholders (primarily customers) perceived the Charity. The outputs of this research were presented at a workshop on 21st June and have provided objective verification of perceptions that we anecdotally understood, as well as new insights.

The insights from this activity will inform the production of our reputation improvement plans which we will produce for approval during quarter 2. Our reflections are that this must be integrated with our thinking and plans in relation to the charity re-brand and the culture change work.

Charity re-brand

As outlined above, the domain name change will be enacted in August. Re-worked STAH logos were presented to the Executive Team but agreement was not reached on these with subsequent reflections on the breadth and depth of what 'brand' actually is and the significance of the logos alone. Our intention is revisit the re-brand plans in light of these reflections as well as being able to take account of the feedback from the RbD reputation work and some of the elements of the Lead the Change programme. Our emergent thinking being that how we think, act and behave must reinforce our external signalling and that this is intrinsically linked to the culture change work.

Priority area metrics

The key metrics to understand whether we are positively impacting towards our strategic objectives are:

- Reputation
- Brand recognition
- Campaign reach
- Campaign impact
- Service utilisation (90%+)

Through the RbD work we have a baseline qualitative and quantitative assessment of reputation and as part of the overall programme of work will be re-measuring this in 12-18 months' time, however we will need to establish an ongoing metric that we can measure ourselves. Of the other required measures, only the measurement of service utilisation is currently possible and is accessible through the IPR dashboard, although is not intuitive / obvious. We are discussing with the BI Team how we can improve visibility of utilisation at a ward level and the associated reporting and monitoring.

Additionally we have asked for an initial informal expert view from RbD on the development of the other metrics.

Collaboration and system working

Our system interactions remain largely the province of the Strategic Partnerships Team, but we know that a broader and deeper set of relationships will be required if we are to increase our relevance and how we help in health and care systems. During the period we have produced a detailed overview of the health and care system and worked through this in a specific SLT session.

However, this is a further area where cultural and behavioural change is required to drive the willingness of people to be involved and increase their competence to do so in positive and effective ways. We are working with the Learning & Development team around how we can provide training and development in this area and perceive that expectation setting through the IPDR / objectives process that this is a required behaviour and activity would also be required to drive change.

We have commenced assessing potential partners for strategic alliances that will support our aims of repositioning the Charity and additionally are pursing joining the Association of Mental Health Providers, an action that will support the increasing of our presence and relevance as a leading mental health charity, aligning us with the VCSE sector and within an Association that has other prominent mental health charities as members.

## Service Innovation

This priority area had one milestone due in Q1 2022/23: *Establish Business Development Team (by Q2).* The recruitment to the Business Development Team is behind plan following an unsuccessful first recruitment round however appointments have been made and the team are now in post and will have concluded their induction by then end of July.

The delay in recruiting will have an impact on the subsequent milestones of completing a broad options analysis and outline of opportunities ahead of a gateway review and approval at the September Board. This review will be deferred until the November Board.

Business Development Capability

In addition to the recruitment to the Business Development Team we have established a monthly business development meetings aimed at engaging the wider organisation in understanding and committing to participation in this essential activity. Participants recognise that we are in the early stages of taking this activity forwards but have 'signed up' to a way of working that requires them to be prospective, proactive and ask the question *"how can we…."* In order that we challenge the current norms to help achieve our ambitions.

Additionally we have assessed and selected a tool that will provide us with public sector market insight and visibility that we currently do not have that will help us to be more prospective and proactive in regards to procurement opportunities.

Community Partnerships Expansion
We continue to grow the Community Partnerships service and have secured a number of new contracts for both Criminal Justice and neurodevelopmental assessment services in line with our proposed activity / focus.

CQI improving current services
A CQI team has been established as well as a CQI forum. A number of CQI projects are currently underway and delivering results with a number of cross functional initiatives being led by enabling staff (e.g. pharmacy) that will have impact across multiple wards and teams.

Priority area metrics
We have identified that the key metrics to understand whether we are positively impacting towards our strategic objectives are:

- total # community beds
- community bed types
- Community Partnerships income
- Income from non-bed based services (not CP)
- Service diversity
- Payor diversity
- # CQI initiatives

Few of these are currently being measured / reported and of those that are, the visibility of these is variable. As part of the work over the coming period we will begin to establish the measurement and reporting of these metrics.

## Research & Innovation

This priority area had one milestone due in Q1 2022/23: *Establish an enlarged and combined 'research and education hub' in the historic Northampton hospital building with input from our academic and industry partnerships.*

This milestone is overdue, impacted by the absence of operational leadership and organisational clarity around the underpinning architecture and structure for our research and education ambitions. Our intent is to resolve this through Q2/3 2022/23 and reschedule delivery of the milestone for Q4 2022/23.

Associated with this and the process for decision making in regard to investment in Research and Innovation, we have rescheduled the milestone for targeted funding from the Charity to Q4 2022/23.

In pursuit of our wider ambitions for this priority area in the period we have:

- Approved the Research Strategy through the Board in May 2022
- Commenced initial discussions with Nottingham and Loughborough Universities around building partnership relationships with key academic institution

**Education & Training**

No milestones were scheduled for delivery in this quarter, instead the activity undertaken – as detailed below – is supporting the delivery of future milestones, building the foundations or strengthening existing arrangements.

St Andrew's College
We have appointed Ruth Bagley, NED as new Chair of St Andrew's Governing Body.

Pupils took part in World Book Day and Children Mental Health Awareness day in March and have taken part in Horse Riding and Rock-Climbing events as well as Duke of Edinburgh Chrome Hill challenge in Peak District. In June we had an expressive arts day and celebrated Pride.

We have reached over 11,500 pupils in schools in Northamptonshire under the Lightbulb Mental Health Awareness Programme and held a successful mental health for schools conference in May. Cheryl Smith was awarded the University of Northampton Community Changemakers Award 2022 for the development of the Lightbulb programme.

Workbridge
We have had our first service user/learner gain a job in the retail team as a Specialist Print Assistant (making customer pictures and canvases).

The restructure within Workbridge, which sees it move to a vocational learning strategy, has now been completed and we are moving into stage two of the plan, whereby Workbridge and the Adult Education team work together as one team, sharing expertise and ensuring overlaps in service provision are smooth. This part of the project needs an expert in the field of patient education and therefore responsibility has passed to Cheryl Smith, the Head Teacher of our CAMHS College and leader of the Adult Education Team.

REDS Recovery College and Peer Support Workers
Annual learner numbers for the Recovery College (April 2021-2022) was 2120. We have had 353 learners during April and May 2022 plus 272 learners in June, including 5 external courses to community groups, SEN young person's development programme and IMPACT Provider Collaborative.

Power of Language & Attitudes course was delivered to 22 wards or teams, 113 staff and 66 patients over last three months (total 179 people) as part of the Quality Improvement Plan.

We have 12 Peer Support Workers (PSW) working on 10 wards providing 218.5 hours peer support to patients per week. Three more are due to join shortly and 5 more are in the pipeline.

We secured Health Education England (HEE) funding for peer support training for 12 PSWs and 4 peer managers during 22/23.

Learning & Development
We have secured funding from Health Education England to fund the ASCEND programme and we will be offering an MBA programme with Keele University funded by the Apprenticeship Levy. We are also offering six places in MSc in Clinical Associate Psychology Degree at Exeter University.

We achieved revalidation with our Partnership with University of Northampton achieving four commendations:

1. Celebrating our close working relationships and common values between UoN & St Andrew's in creating public benefit throughout Northamptonshire
2. Our creative and proactive curriculum design which anticipates skills needed for the future and includes co-production
3. Our commitment in ensuring inclusive access to learning, regardless of educational back ground
4. Our people/learner centred approach; where students felt listed to and valued.

Trauma Development Centre

On 22nd March 134 delegates from 11 countries around the world joined the 2nd International Moral Injury in Occupational Settings Conference, co-hosted by the Crisis, Disaster and Trauma Section of the British Psychological Society (BPS), the Centre for Developmental and Complex Trauma, and the Academic Centre, St. Andrew's Healthcare. The day saw speakers presenting from five different time zones on the conceptualisation of moral injury and its place in diagnostic manuals, the systemic context in which moral injury occurs, and interventions and innovations for reducing the risk of moral injury in a range of occupational settings.

Our most recent paper, exploring the factor structure of the Moral Injury Events Scale in forensic mental healthcare staff, is in submission to the Journal of Forensic Psychiatry and Psychology. Alongside last year's moral injury staff survey, as a two-part submission.
We are working through validation and legalities with the University of Buckingham to offer MSc Trauma and expect to offer the first postgraduate programme next year with six more trauma postgraduate programmes to follow.

We have had two papers accepted at an International Complex Trauma conference in Israel. The second paper relates to some of the DBT trauma work we have been undertaking.

We have commenced the planning for our third International 'Trauma Informed Care' Conference that we will be co-hosting with Crisis, Disaster and the Trauma Section of the British Psychological Society in November 2022

Medical Students

The number of medical students from University of Cambridge has been rising steadily and they will nearly double the number from University of Buckingham. Buckingham numbers continue to steadily increase along with associated income.

The feedback from medical students from both Cambridge and Buckingham continues to be extremely positive. Given the recent changes in personnel at our Essex site we are exploring the option of returning some or all of the Cambridge students to Essex which traditionally was their most popular placement.

School of Nursing

We are working with Health Education England and Lincolnshire NHS Trust to provide mental health training for International Students

# Appendix 1 – Strategy Milestone Tracker

| STRATEGIC PRIORITY | AIM | MILESTONE OBJECTIVES | | INDIVIDUAL OBJECTIVE | | Scheduled completion | Assessed by | Assessed on | Commentary / Update |
|---|---|---|---|---|---|---|---|---|---|
| Quality | Deliver high quality care and recovery outcomes through our quality first ethos | Quality Care that is fit for the future | | To be delivering improved patient outcomes in a consistent manner across all service | | 2023/24 | | | Quality Matrons in place, Each ward has clinical treatment model. Your Voice being implemented |
| | | | | All services to be rated GOOD or to have improved as a minimum at the next CQC inspection | | 2024/25 | Jenny Kirkland | 04/07/2022 | All wards have own QIP, Charitywide QIP. Buddy quality workstreams. Quality Improvement Director in place. |
| | | | | To implement innovative models of practice and technology to support and improve the experience and outcomes for our service users | | 2023/24 | Jenny Kirkland | 04/07/2022 | E-obs implemented. Body cameras implemented in specific areas with CCTV policy and process updated. Oxi health being considered. Workforce development to include Ascend & Aspire. Exploring roles & responsibilities within clinical areas to ensure appropriate and creative division of tasks to meet clinical need of patients. quality leading indicator metrics requested to support oversight and improvement work (currently delayed without expected delivery date due to IT capacity issues). |
| | | | | We will have an agreed physical health strategy to improve the physical health of our patients | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Physical Healthcare strategy written |
| | | | | Physical health strategy plan implemented | | 2023/24 | Jenny Kirkland | 04/07/2022 | Physical healthcare dashboard implemented. Physical healthcare training including NEWS2 and neuro obs being provided. |
| | | Minimising patient harm and delivering safe care | | We will have an agreed patient safety strategy ensuring that safe care is central to all we do, and aligned to the NHS practices | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Patient safety implementation plan drafted awaiting publication of National PSIF (due June but delayed until July). |
| | | | | Patient safety strategy delivery training plan implemented | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | |
| | | | | Funded Clinical Equipment budget with policy and processes to support Charity's ongoing need | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Clinical equipment officer post, lead resus officer post being recruited to. Finance agreed initial clinical equipment budget to agree plan for implementation. |
| | | | | To have timely and accurate information about quality, compliance and safety indicators accessible to all ward staff to support and to be routinely used in the clinical governance structure | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Patient safety framework, ward board and daily flash dashboards available. Request made to IT team to support compliance information and leading indicators at ward and divisional level (awaiting completion date (delayed due to IT capacity and focus on Allocate). |
| | | | | Implementation of an agreed Quality Team structure to support frontline staff to achieve the overall improvements identified in the safety strategy | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Quality strategy in draft with quality architecture being developed. |
| | | Delivering a great patient experience | | We will have greater patient engagement and involvement - plans agreed and implemented | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Co- production strategy going to People Committee in July. |
| | | | | We will increase the quality, type and availability of information about the services provided, treatments, models of care accessible to patients and carers to support collaborative decision making | | 2023/24 | Jenny Kirkland | 04/07/2022 | |
| | | | | We will have improvements in patient engagement and satisfaction of services | | Q4 2022/23 | Jenny Kirkland | 04/07/2022 | Your voice implemented. |

| Progress Level | Description |
|---|---|
| Substantial Progress | Substantial progress is being made on achieving strategic objectives and measures. Objectives and measures may already have been achieved or are either on track or ahead of plan for achieving them. |
| Adequate Progress | Although there are some recognised control gaps, they are not sufficiently critical to compromise the achievement of the strategic objectives or measures. Management are generally on track in terms of agreed timelines and milestones for the relevant objectives/measures. Where progress is slightly behind plan, management have confirmed and realistic plans in place to address the slippage. |
| Partial Progress | The control gaps, or lack of progress in completing agreed actions, taken together or individually may indicate the strategic objective or measure will not be achieved in the agreed timescale or as initially intended. Management and objective owners may need to complete additional actions to remain on track in terms of agreed timelines and milestones, however they remain at an early stage. |
| Limited Progress | Targets and milestones have been missed, or management have not commenced the necessary actions required in order to achieve the strategic objective or measure. Significant actions and activities are required by management to address the shortfall in progress. |
| Not planned to have commenced | Work to deliver on this objective not planned to have commenced at present time |

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|---|---|---|---|---|---|---|---|---|---|
| Workforce Resilience and Agility | To be an organisation that focusses on the well-being and creativity of its staff and supportive eco-system to deliver an adaptive and resilient organisation and system capable of responding rapidly to new opportunities or threats | We will be externally recognised as a leading employer of choice for wellbeing | | Increase the ability of our staff to work flexibly including more flexible shift patterns, ways of working and contracts. | | Q2 2023/24 | Simone Wetherall | 05/07/2022 | Flexibility in clinical shifts being promoted by recruitment as a benefit in comparison to local competitors. Still inconsistency regarding which wards are promoting flexible shift patterns and flexing rotas according to patient acuity. Further work needed to gain consistency/ HR Workchoice project progressing. |
| | | | | Offer competitive pay for key roles including supporting our lowest earners | | Q3 2022/23 | Simone Wetherall | 05/07/2022 | Pay benchmarking of key roles ongoing and BAU. Currently awaiting NHS pay review decision announcements. Additional out of cycle pay review to encourage pay discussions. |
| | | | | To be externally recognised for our commitment to wellbeing | | Q2 2023/24 | Simone Wetherall | 05/07/2022 | Market research on external charters completed. Analysis required to determine cost vs, benefit of non-free options. Workplace Wellbeing charter, a basic free charter will be explored initially.. |
| | | We will have a culture of wellbeing where our staff feel valued by the Charity and its leaders | | We will upskill line managers to have better conversations about wellbeing | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | Partnered with REDS Recovery College to start designing training. Next phase is engaging with clinical teams for further design and implementation planning. Manager guide for supporting staff absent from work created in partnership with absence project. |
| | | | | Lead the Change programme has impacted organisational culture | | Q1 2023/24 | Simone Wetherall | 05/07/2022 | Initial quick wins from programme will be presented to CEC on 6/7/22. Wellbeing actions will be implemented as soon as possible |
| | | | | Roll out Compassion-focused Staff Support training to 90% wards by end 22/23 | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | New delivery plan agreed with supplier where by bitesize version of the course will be delivered more widely by 13 CFSS champions across charity. Next step to create plan detailing where and when training will be delivered |
| | | | | Improve the food provision at night and quality of rest areas across all sites | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | Identified as quick wins by Lead the Change project, to be taken to CEC for decision 6/7/22. Head of wellbeing working closely with E&F as their project progresses. In June, analysis of rest areas completed and café tills have been upgraded to provide infrastructure for improvements to food provision. Funding for improvements TBA by E&F |
| | | | | By end of July 22 to have delivered a staff party | | Q2 2022/23 | Simone Wetherall | 05/07/2022 | Staff Party planning almost complete, co-produced with staff. Tickets delivered and approval granted to go ahead 14/7/22 |
| | | | | Improve staff mental health offering | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | Currently exploring options. Plan to communicate current offering better on "wellbeing Wednesdays" |
| | | | | Improve physical wellbeing options for staff | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | Currently exploring options. Wellness Walk in design with REDS academy. Planned to start in July. Working with Comms to communicate current offering better on "wellbeing Wednesdays" |
| | | | | Deliver "thank you gift" / Wellbeing Hampers to all staff | | Q1 2022/23 | Simone Wetherall | 05/07/2022 | Exploring alternative options to Wellbeing Hampers and other options may be more appropriate. Discussions still underway. Blue Light Card will be offered to Staff as a Financial Wellbeing Gift. Working with payroll to finalise recharging procedure. |
| | | | | Supporting Transition to BAU Wellbeing | | Q4 2024/25 | Simone Wetherall | 05/07/2022 | |
| | | We will be connected to our communities, sharing wellbeing resources and expertise | | Develop wellbeing products that can be sold externally | | Q4 2023/24 | Simone Wetherall | 05/07/2022 | |
| | | | | Improved partnership with regional providers | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | Head of wellbeing participating in Regional Sub groups and H&WB forum meetings. |
| | | | | Delivery of wider CSR/ESG strategy/plan | | Q4 2022/23 | Simone Wetherall | 05/07/2022 | ESG Progress update going to CEC in August 2022, then to board in September |
| | | We will be a learning organisation better able to adapt to future changes | | New roles created to support future focus of Charity | | Q2 2024/25 | Simone Wetherall | 05/07/2022 | Head of wellbeing working in partnership with Dep. Dir Workforce planning as People Plan is finalised |
| | | | | Increase uptake in non-mandatory training | | Q3 2023/24 | Simone Wetherall | 05/07/2022 | Access to training highlighted as quick win for Change Leaders. New ideas will be explored as part as part of this project. |

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|---|---|---|---|---|---|---|---|---|---|
| Finance and Sustainability | Charitable and strategic aims are delivered through a values driven financial culture where income exceeds expenditure to enable the reinvestment the care and services we provide<br><br>Generate sufficient surplus to be invested in Research, Innovation and Services, all without the need of any cashflow funding. Sustaining this position to support and assist the achievement of all other elements of the strategy | **Generate a surplus at business unit and charity levels** | | Achievement of the annual budget | | Q4 2022/23 | Kevin Mulhearn | 04/07/2022 | May 22 YTD budget achieved - ongoing operational risks exist as reflected in Full Year Forecast Finance Committee/Board paper |
| | | | | Achievement of financial savings associated with revised staffing model | | Q1 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed - achieved my removing two roles in Jan 2022 when new staffing model went live |
| | | | | Achievement of financial efficiencies associated with new e-scheduling tool | | Q3 2022/23 | Kevin Mulhearn | 04/07/2022 | |
| | | | | Agreement of 2022/23 budget timetable complying with stakeholder requirements and RCF replacement | | Q3 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | Agreement of budget setting policy | | Q4 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | Agreement of 2022/23 budget with outturn aligned to 2021/22 plan | | Q4 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | Preparation, agreement and actioning of phase 1 de-risking plan | | Q1 2022/23 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | Agree ongoing cycle of IT investment and incorporated into financial forecasts | | Q1 2022/23 | Kevin Mulhearn | 04/07/2022 | Completed as part of budget cycle. Process ongoing via Finance & Contracts and annual established process/cycle |
| | | | | Agree ongoing cycle of Estates and facility investment and incorporated into financial forecasts | | Q1 2022/23 | Kevin Mulhearn | 04/07/2022 | Completed as part of budget cycle. Process ongoing via Finance & Contracts and annual established process/cycle |
| | | | | Complete review of Charity Operating Model and Cost Improvement Program | | Q3 2022/23 | Kevin Mulhearn | 04/07/2022 | |
| | | | | Create process and model for Strategic Investment and New Market Appraisal | | Q3 2022/23 | Kevin Mulhearn | 04/07/2022 | |
| | | | | New Business - Market analysis of Adjacent and Radical opportunities completed | | Q4 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | New Business - Completion of the new team structure | | Q3 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | New Business - Completion recruitment of the initial team structure | | Q1 2022/23 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | New Business - Completion of SOP's for new business teams and creation of pipeline and associated processes | | Q3 2022/23 | Kevin Mulhearn | 04/07/2022 | |
| | | | | RCF - appointment of professional advisors | | Q4 2021/22 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | RCF - creation of supporting financial modelling & data room information | | Q1 2022/23 | Kevin Mulhearn | 04/07/2022 | Completed |
| | | | | RCF - Negotiation of new facility | | Q2 2022/23 | Kevin Mulhearn | 04/07/2022 | Ongoing |
| | | | | RCF - Replacement facility in place | | Q3 2022/23 | Kevin Mulhearn | 04/07/2022 | |
| | | **Meet the ESG requirements applicable over the strategy lifetime** | | ESG Strategy created | | Q3 2022/23 | Kevin Mulhearn | 04/07/2022 | KM/AT joint owner. Future Director Program Team leading initial review of ESG. Will be presented to Exec in July along with Green Plan. KM/AT then to review next steps of Strategy |
| | | | | ESG Strategy approved | | Q2 2022/23 | Kevin Mulhearn | 04/07/2022 | |
| | | | | ESG Strategy implementation commences | | Q2 2022/23 | Kevin Mulhearn | 04/07/2022 | |

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|---|---|---|---|---|---|---|---|---|---|
| Partnerships and Promotion | To reposition STAH as an anchor institution and valued local asset in all populations we serve as well as having a prominent national profile as a recognised champion and expert for those we help<br><br>We will increase our relevance and become the partner of choice for service delivery, research and education | Achieved and sustaining a positive reputation with a broad range of stakeholders | | Reputation Assessment & Improvement (RbD)<br>Quant & Qaul assessment phase | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Initial baseline assessment completed and feedback workshop delivered |
| | | | | Reputation improvement plan agreed | | 2022/23 Q2 | Eddie Short | 01/07/2022 | Initial planning session scheduled for 4th July |
| | | | | Reputation metrics established | | 2022/23 Q2 | Eddie Short | 01/07/2022 | Advice sought from RbD on possible approaches |
| | | | | Improvement plan delivery | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Quant & qaul re-measure | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | Have positive national recognition / awareness of the Charity and the work it does | | **Re-brand for charity clarity** | | | | | |
| | | | | Domain name change to .org | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Change will occur mid -August. Circa 6 weeks beyond target date |
| | | | | Update branding / visuals | | 2022/23 Q2 | Eddie Short | 01/07/2022 | Approach being reconsidered: felt that we may be prioritising the logo / visuals above the wider re-branding. Applied for membership of AMHP as part of repositioning activity |
| | | | | **Promotion of STAH as a charity** | | | | | |
| | | | | Co-produce long term campaign & ongoing refresh approaches into BAU | | 2022/23 Q3 | Eddie Short | 01/07/2022 | |
| | | | | Develop brand recognition metrics and measurement cycle | | 2022/23 Q3 | Eddie Short | 01/07/2022 | Advice sought from RbD on possible approaches |
| | | | | Deliver campaign and formalise as BAU | | 2024/25 | Eddie Short | 01/07/2022 | |
| | | Support core services utilisation, new service developments and research & education opportunities | | **Establish partnership working within relevant H&SC systems** | | | | | |
| | | | | Full partner in IMPACT PC | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Risk & Benefit share held up by IMPACT |
| | | | | Full partner in Reach Out PC | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Full partner incl. risk and benefit share |
| | | | | Full partner in EM CAMHS PC | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Risk & Benefit share not yet determined - a different approach being sought by PC |
| | | | | Partner in East of England PC | | 2022/23 Q1 | Eddie Short | 01/07/2022 | As far embedded as IS providers are allowed to be and positive relationships |
| | | | | Partner in Northamptonshire ICS | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Engaged in the ICS at a strategic level - need to move this to engage a wider group of STAH employees |
| | | | | Developed presence in Northamptonshire 3rd sector community | | 2022/23 Q1 | Eddie Short | 01/07/2022 | Engaged in the H&WB forum - need to gain greater involvement and participation across the Charity |
| | | | | Commence creating service propositions with partners (when BDT in place) | | 2022/23 Q3 | Eddie Short | 01/07/2022 | Awaiting BDT to be in place |
| | | | | **Build internal skill, capacity and engagement to collaborate** | | | | | |
| | | | | Shared SLT understanding of system(s) | | 2022/23 Q1 | Eddie Short | 01/07/2022 | System paper shared. Additional work to embed understanding required |
| | | | | Develop charity and partnership supporting behaviours to enable uniform engagement and representation of the Charity perspectives | | 2022/23 Q3 | Eddie Short | 01/07/2022 | |
| | | | | Develop collaboration skills | | 2022/23 Q4 | Eddie Short | 01/07/2022 | |
| | | | | Engage (appropriate) wider workforce in collaboratives, with partners etc. | | 2022/23 Q4 | Eddie Short | 01/07/2022 | |
| | | | | **Establish wider strategic partnerships** | | | | | |
| | | | | Housing partners<br>Explore & nurture | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Collaborative service development | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Service delivery partners<br>Explore & nurture | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Collaborative service development | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Research partners<br>Explore & nurture | | 2024/25 | Eddie Short | 01/07/2022 | |
| | | | | Collaborative research | | 2024/25 | Eddie Short | 01/07/2022 | |
| | | | | Education partners<br>Explore & nurture | | 2025/26 | Eddie Short | 01/07/2022 | |
| | | | | Collaborative service development | | 2025/26 | Eddie Short | 01/07/2022 | |
| | | Enable marginalised voices to be heard in order to influence and impact positive change | | **Advocacy & campaigning**<br>Develop our approach to issues led campaigning | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Campaign reach and impact metrics established | | 2023/24 | Eddie Short | 01/07/2022 | Advice sought from RbD on possible approaches |
| | | | | Develop 23/24 campaign(s) | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Deliver & measure impact of 23/24 campaign(s) | | 2023/24 | Eddie Short | 01/07/2022 | |
| | | | | Develop 24/25 campaign(s) | | 2024/25 | Eddie Short | 01/07/2022 | |
| | | | | Deliver & measure impact of 24/25 campaign(s) | | 2024/25 | Eddie Short | 01/07/2022 | |
| | | | | Develop 25/26 campaign(s) | | 2025/26 | Eddie Short | 01/07/2022 | |
| | | | | Deliver & measure impact of 25/26 campaign(s) | | 2025/26 | Eddie Short | 01/07/2022 | |
| | | | | Develop 26/27 campaign(s) | | 2026/27 | Eddie Short | 01/07/2022 | |
| | | | | Deliver & measure impact of 26/27 campaign(s) | | 2026/27 | Eddie Short | 01/07/2022 | |

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| STRATEGIC PRIORITY | AIM | MILESTONE OBJECTIVES | | INDIVIDUAL OBJECTIVE | | Scheduled completion | Assessed by | Assessed on | Commentary / Update |
|---|---|---|---|---|---|---|---|---|---|
| Service Innovation | We will create and establish a range of care, support and treatment offers that meet the expressed and observed current needs, as well as anticipated future needs, across diverse markets, geography, customers and income sources.<br><br>Our existing services will continuously innovate and improve in order to remain relevant and well utilised and ensure value for those that commission and fund them | **By Quarter 1 2023/24 we will have in place the required infrastructure and Board approved opportunities that will allow us to undertake business development** | | Establish Business Development Team | | Q1 2022/23 | Sanjith Kamath | 01/07/2022 | All 4 posts recruited to and will be in place and inducted by end of July |
| | | | | Create initial processes and methodologies | | Q2 2022/23 | Sanjith Kamath | 01/07/2022 | Tussell tool procured. Processes etc. will be a primary focus of the BDT on commencement |
| | | | | Initial Market Analysis (Invicti) | | Q4 2021/22 | Sanjith Kamath | 01/07/2022 | Completed - Niche Report and Invicti Report obtained and presented to the Executive Team |
| | | | | Options analysis and opportunities outline | | Q3 2022/23 | Sanjith Kamath | 01/07/2022 | Not started - will be a primary focus of BDT once in place |
| | | | | Gateway review and approval (September Board) | | Q3 2022/23 | Sanjith Kamath | 01/07/2022 | Due to delay in establishing BDT the Board review will be deferred to November to give time for the analysis and appraisal work to be carried out |
| | | | | Business case(s) development | | Q4 2022/23 | Sanjith Kamath | 01/07/2022 | Not started |
| | | | | Opportunity selection and authorisation (January Board) | | Q4 2022/23 | Sanjith Kamath | 01/07/2022 | Not started |
| | | **Developed and delivered community bed based service that meets the needs of local and regional systems initially focussed on services where core competencies can be transferred to meet the known demand** | | Development subject to opportunity selection (above) | | TBD | Sanjith Kamath | 01/07/2022 | Not started |
| | | | | | | | | | |
| | | **Created a range of new non-bed based service offers focussed on new markets and /or customers, targeting 5% of the perceived Total Addressable Market in each identified sector** | | Development subject to opportunity selection (above) | | TBD | Sanjith Kamath | 01/07/2022 | Not started |
| | | | | | | | | | |
| | | **Expanded the proven Community Partnerships offers to more customers, targeting an income of circa £10m in 2026/27** | | Neurodevelopmental service (ASD assessments) - circa 2000 assessments PA by 2025/26 | | 2025/26 | Sanjith Kamath | 01/07/2022 | Opportunities to expand being explored in Birmingham as well as through possible partnership in Norfolk |
| | | | | Veterans - acquire new work through armed services covenant opportunities | | 2023/24 | Sanjith Kamath | 01/07/2022 | Not started |
| | | | | Outpatients - grow outpatients service starting with West Midlands | | Q3 2022/23 | Sanjith Kamath | 01/07/2022 | Work in progress |
| | | | | Criminal Justice - acquire new MHTR work in new geographies targeting 3 x new services across 2023-2026 | | 2025/26 | Sanjith Kamath | 01/07/2022 | MHTR work won and ongoing discussions re: other opportunities |
| | | **Deliver ongoing improvements to outcomes, experience and effectiveness to increase customer value in every service** | | Minimum of 1 CQI initiative undertaken in >50%of services in year | | 2023/24 | Sanjith Kamath | 01/07/2022 | A CQI team has been established as well as a CQI forum. A number of CQI projects are currently underway and delivering results. |
| | | | | Minimum of 1 CQI initiative undertaken in 100%of services in year | | 2024/25 | Sanjith Kamath | 01/07/2022 | Not started |
| | | | | Minimum of 2 CQI initiatives being undertaken in each ward / unit / service PA | | 2025/26 | Sanjith Kamath | 01/07/2022 | Not started |
| | | | | Minimum of 4 CQI initiatives being undertaken in each ward / unit / service PA | | 2026/27 | Sanjith Kamath | 01/07/2022 | Not started |

| Progress Level | Description |
|---|---|
| Substantial Progress | Substantial progress is being made on achieving strategic objectives and measures. Objectives and measures may already have been achieved or are either on track or ahead of plan for achieving them. |
| Adequate Progress | Although there are some recognised control gaps, they are not sufficiently critical to compromise the achievement of the strategic objectives or measures. Management are generally on track in terms of agreed timelines and milestones for the relevant objectives/measures. Where progress is slightly behind plan, management have confirmed and realistic plans in place to address the slippage. |
| Partial Progress | The control gaps, or lack of progress in completing agreed actions, taken together or individually may indicate the strategic objective or measure will not be achieved in the agreed timescale or as initially intended. Management and objective owners may need to complete additional actions to remain on track in terms of agreed timelines and milestones, however they remain at an early stage. |
| Limited Progress | Targets and milestones have been missed, or management have not commenced the necessary actions required in order to achieve the strategic objective or measure. Significant actions and activities are required by management to address the shortfall in progress. |
| Not planned to have commenced | Work to deliver on this objective not planned to have commenced at present time |

| STRATEGIC PRIORITY | AIM | MILESTONE OBJECTIVES | INDIVIDUAL OBJECTIVE | Scheduled completion | Assessed by | Assessed on | Commentary / Update |
|---|---|---|---|---|---|---|---|
| Education and Training | To become an established major player in providing education and training in mental wellbeing and leadership, providing patients and staff at STAH and beyond the opportunities to learn, achieve and maximise their potential<br><br>- Establish STAH as the premier mental health and learning disabilities education and training organisation<br><br>- Education & Training income to represent a significant % of the overall work of the charity by 2027 | We will develop our Recovery College and Peer Support Strategy and integrate Workbridge Vocational Learning | Peer Support Workers on 100% of St Andrew's Wards as Business as Usual | Q4 2024/25 | Donna Walker | 20/06/2022 | 12 PSW's providing 218.5 hours peer support to patients per week. Recruitment in progress for ward based and Workbridge peer support roles. |
| | | | Host Peer Support Conference | Q2 2024/25 | Donna Walker | 20/06/2022 | Building networks with other peer support providers. |
| | | | Recovery College - we will expand our offering increasing the number of students undertaking and developing courses | Q4 2024/25 | Donna Walker | 20/06/2022 | Annual learner numbers 2120 from April 2021-22, 353 during April & May 2022 |
| | | | Restructure Workbridge to provide vocational skills placements for internal and external community service users | Q4 2021/22 | Cheryl Smith | 20/06/2022 | Restructure complete, establishing new service delivery model via 5 vocational education 'Hubs'. |
| | | | Increase the number of patient placements | Q4 2024/25 | Cheryl Smith | 20/06/2022 | |
| | | | Scope out potential for registration as Further Education Provider | Q3 2024/25 | Cheryl Smith | 20/06/2022 | |
| | | We will establish the Centre for Developmental and Complex Trauma | We will publish high quality publications each year | 2022/23 | Deborah Morris | 01/07/2022 | We currently have 5 journal papers n submission and have had 9 conference papers accepted at International conference, so far in 2022-2023 |
| | | | We will host trauma and mental health conferences | 2022/23 | Deborah Morris | 01/0/2022 | 2nd International Moral Conference in March 2022 Hosting Third International "Trauma Informed Care Conference" In Nov 22 |
| | | | The clinical impact of our research will lead to Service Improvement initiatives | 2022/23 | Deborah Morris | 01/07/2022 | There are currently four service improvement initiatives in place and one Charity wide initiative |
| | | | Reputation building | 2022/23 | Deborah Morris | 01/07/2022 | New partnerships are being established (US - conference) and with UR NHS research network for research and conference activities |
| | | We will expand our CAMHS Education Offering | Rebranding of Lightbulb quality mark | Q3 2021/22 | Cheryl Smith | 01/07/2022 | Complete |
| | | | We will accredit schools in our community and nationally | Q4 2024/25 | Cheryl Smith | 01/07/2022 | 30 schools reaching over 11,500 pupils |
| | | | We will host an annual mental health conference for schools each year | TBD | Cheryl Smith | 01/07/2022 | |
| | | | We will provide careers fairs within our community and offer nursing scholarships | TBD | Cheryl Smith | 01/07/2022 | x2 nursing scholars in post. Next cohort should next be recruited in Spring 2023 for September start |
| | | | We will market map and develop a proposal to run schools in the community for young people with mental health and learning disabilities | Q3 2022/23 | Cheryl Smith | 01/07/2022 | |
| | | | We will open a specialist MH/LD school (subject to above) | Q4 2024/25 | Cheryl Smith | 01/07/2022 | |
| | | We will provide External Learning and Development | We will market map the opportunities for providing and being an external L&D Provider | Q3 2022/23 | Martin Kersey | 01/07/2022 | Searching for a supplier to do this work has been difficult. We are reviewing options. |
| | | | We will develop a proposal to become an external provider (subject to market mapping) | Q1 2023/24 | Martin Kersey | 01/07/2022 | |
| | | | We will provide external L&D 9subject to above) | Q4 2024/25 | Martin Kersey | 01/07/2022 | |
| | | We will provide Student and post graduate education | We will develop and deliver post graduate programmes in trauma | Q4 2024/25 | Deborah Morris | 01/07/2022 | Seven Programmes developed ..Delivery will commence 2023 |
| | | | We will run MSc practitioner in psychological trauma, PG Diploma and Certificate in Complex Trauma | 2023/24 | Deborah Morris | 01/07/2022 | Delivery in 2023 |
| | | | We will run Level 4 certificate in Higher Education and deliver post graduate programmes for Nursing | 2023/24 | Deborah Morris | 01/07/2022 | Post graduate PGE Leadership due for validation in early 2023 |
| | | | We will increase the encumber of undergraduate medical training | 2023/24 | Martin Kersey | 01/07/2022 | Doubled Number of medical students in 2022 |
| | | | We will market map and develop proposal to become a formal teaching hospital | Q4 2024/25 | Martin Kersey | 01/07/2022 | |
| | | Learning and Development | We will develop new roles/skills and competencies to ensure that the Charity workforce is fit for purpose | Q2 2022/23 | Holly Taylor | 01/07/2022 | Developing at pace with ASCEND grant (200k) and Clinical Psychology Associate as 2 roles in development. |
| | | | We will grow our talent, expand our career pathways and workforce planning | Q2 2022/23 | Holly Taylor | 01/07/2022 | Creating a dedicated resource to career development. Career Cafes are 'on the road' again now COVID restrictions are lifted. |
| | | | We will expand our apprenticeships | Q2 2022/23 | Holly Taylor | 01/07/2022 | A range of new apprenticeships are in place from L2-7, particularly in our Estates and Facilities job family. |

| Progress Level | Description |
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| STRATEGIC PRIORITY | AIM | MILESTONE OBJECTIVES | INDIVIDUAL OBJECTIVE | Scheduled completion | Assessed by | Assessed on | Commentary / Update |
|---|---|---|---|---|---|---|---|
| Research and Innovation | STAH's Research & Innovation will support the delivery of our strategic objectives in a highly visible, reputation enhancing and financially sustainable way. Research & Innovation will become a far greater focus of the Charity's work & profile by 2027 | Nurturing strong relationships with suitable and strategically aligned academic institutions | Build a relationship with our first key academic institution, including contractual arrangements | Q3 2022/23 | Kieran Breen | 04/07/2022 | Initial discussions have taken place with two universities about the interest for jointly funded academic posts although no contractual arrangements have been established |
| | | | Build a relationship with our second key academic institution | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Establish an enlarged and combined 'research and education hub' in the historic Northampton hospital building with input from our academic and industry partnerships | Q1 2022/23 | Kieran Breen | 04/07/2022 | The research strategy was approved by the Board in Q1 2022 and an implementation plan needs to be developed |
| | | | Build a relationship with our third key academic institution | 2024/25 | Kieran Breen | 04/07/2022 | |
| | | | Grow the number of PhD students and MSc students across the three partner universities | 2023/24 | Kieran Breen | 04/07/2022 | This will follow the development of the University partnerships |
| | | | Establish the St Andrew's 'research triumvirate' by further integrating the three academic institutions within the burgeoning St Andrew's Research Hub | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | Developing a research capability with appropriate staffing, skills and seniority | Recruit to one joint post (Professor level) and one full time Lecturer/research assistant to support the new partnership with our first academic institution. | Q4 2022/23 | Kieran Breen | 04/07/2022 | Initial discussions have taken place with two universities about the interest for jointly funded academic posts |
| | | | Recruit to a second joint post (Professor level) and first senior lecturer (joint post) with a lecturer/research assistant to support our second academic institution and research themes. | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Recruit a second senior lecturer (joint post) and third lecturer/research assistant with final partner academic institution. | 2024/25 | Kieran Breen | 04/07/2022 | |
| | | | Continue to develop a strong research collaboration across the triumvirate organisations | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Develop strong research partnerships nationally and internationally in collaboration with the academic triumvirate. | 2024/25 | Kieran Breen | 04/07/2022 | |
| | | | Continue research secondments for one or two qualified and motivated staff on a two yearly basis | Q4 2022/23 | Kieran Breen | 04/07/2022 | Initial enquiries have been made by staff. This will be discussed at the fundraising group and the research committee in August 2022 |
| | | Building a strong research culture across St Andrews | Hold one high quality conference with a partner academic institution and engage research champions in each division | Q3 2022/23 | Kieran Breen | 04/07/2022 | Initial discussions have taken place with a University about an exercise-based conference |
| | | | Develop an 'outreach' and training capability with dedicated time from our research team for St Andrews staff. | Q3 2022/23 | Kieran Breen | 04/07/2022 | R&I provide specialised 1-2-1 training for staff and the trauma centre organised a research training course in May 2022 |
| | | | Hold two high quality conferences with two partner academic institutions. | Q4 2022/23 | Kieran Breen | 04/07/2022 | |
| | | | Initiate Quarterly research symposia | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Provide regular updates to staff on new developments in Mental Health through meetings and podcasts, as well as providing ongoing 'outreach' and training | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Hold three high quality conferences with all partner academic institutions | 2024/25 | Kieran Breen | 04/07/2022 | |
| | | | Continue research symposia | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Establish a regular diet of nationally renowned speakers on a diverse range of research and innovation topics | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Establish prestigious bursaries and scholarships for training at our partner Universities through fundraising with the support of our trustees and governors | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | Create a sustainable funding stream | Pump prime research capability with targeted Charity funding | Q2 2022/23 | Kieran Breen | 04/07/2022 | Rescheduling to Q4 2022/23 because in the delay in the implementation of the strategy |
| | | | Generate and support applications for research grants and other income streams from the research through NIHR/MRC etc. | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Obtain recognition from NIHR and NHS to receive patient research funding | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Win first large grant application with the help of our professorial input. | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | Start to win regular national grant applications with sizable awards | 2024/25 | Kieran Breen | 04/07/2022 | |
| | | | The Research and innovation team would be bringing a significant sum of money supported by regular successful joint grant applications to NIHR / MRC / Welcome etc. | 2025/26 | Kieran Breen | 04/07/2022 | |
| | | Impacting on patient care and improving outcomes | We will be able to evidence clearly the impact of R&I activities on our clinical care and patient recovery. | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | We will focus on 5 key research areas to bring maximum benefit and value | 2023/24 | Kieran Breen | 04/07/2022 | |
| | | | The Charity will be carrying out high-quality research as evidenced in peer-reviewed publications and presentations at national and international meetings | 2023/24 | Kieran Breen | 04/07/2022 | |

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|---|---|
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| Paper for Board of Directors | |
|---|---|
| **Topic** | Integrated Quality & Performance Report |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **13** |
| **Author** | Anna Williams, Director of Performance |
| **Responsible Executive** | Professor Oliver Shanley OBE, Interim CEO |
| **Discussed at Previous Board Meeting** | Routine Board paper |
| **Patient and Carer Involvement** | Patient and Carer voice is captured via My Voice inclusion |
| **Staff Involvement** | Staff are involved in the performance processes that feed the analysis and actions |
| **Report Purpose** | Review and comment ☐<br>Information ☒<br>Decision or Approval ☐<br>Assurance ☒ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐ |
| **Strategic Priority Area** | Education and Training ☐<br>Finance & Sustainability ☒<br>Service Innovation ☐<br>Quality ☒<br>Research & Innovation ☐<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☐ |
| **Committee meetings where this item has been considered** | Quality, Workforce and Finance metrics are considered at their associated committees. |

**Report Summary and Key Points to Note**

Review of the period ending June 22

**Quality** – five of the quality KPIs (included in quality scorecard) are showing a special cause improvement at a Charity level (sustained improvements for: Level 2 incidents, restraints, long term segregation, enhanced support episode and staffing levels required for enhanced support). The remaining metrics show common cause variation, with the exception of SIs which is showing a non-statistical trend (where there is a marginal increase and the volume of data points is too low for statistical significance). Assurance is provided for the SI flag and the Division level concerns. At ward level 93% of the quality scorecard KPIs are either in control, have little or no data or show a statistically

insignificant trend. The quality scorecards for each division and ward are routinely shared with QSC. Leading indicators continue to be a focus. My Voice response rates remains a focus. **T**he approach to setting Clinical targets has been agreed at QSC. This paper shares the resulting targets and early performance against baselines.

**People** – at Charity level: training, sickness and agency spend are favourable to target. Sickness has shown a marked improvement, as demonstrated by the Charity level returning to a favourable to target position. The reduction in enabling function absence is ahead of that seen in the divisions – which remain adverse to target. Monthly voluntary turnover is adverse to target – with divisions higher than enabling functions. Nursing establishment remains adverse to target. Projected establishment target achievement dates are being refreshed, in order to incorporate recent recruitment experience and the MHOST review. The refreshed projections will be shared with People Committee in August. The Charity greatly values the experience, passion and commitment of its existing workforce and whilst every effort is being made to attract new personnel to the team, the retention of the existing team is equally vital. There are a number of retention initiatives already in place (shared in the paper) – additionally a complimentary retention plan, including division specific plans, is being finalised.

**Finance** – June 2022 YTD actual performance v budget: net deficit £2.1m - £0.56m lower than budget, with 97.6% achievement of budgeted income offset by positive movement in costs of £1.1m (£0.9m Operational & £0.2m Overheads)

Quality strategy & framework update

The continual focus on quality within the Charity cascades from the strategic perspective all the way to our front line staff delivering quality care. A quality strategy has been drafted, along with a clinical quality governance structure, defining the quality management system that will be applied to the Charity. This focuses on defining the responsibilities and accountabilities for quality planning, control and assurance and includes a focus on the quality improvement approach that is currently being implemented. The structure will also propose clarifications to the lines of assurance from ward to board to ensure full and appropriate clinical governance is implemented in a timely and pragmatic approach. It is anticipated that these will be presented to the Board at the September meeting following the assurance process of QSG and QSC. The successful implementation of these proposals is dependent on support from all functions and especially our Business Intelligence and Information Technology teams, as automating the reporting of compliance data and the presentation of leading quality indicators in a format that is easy for staff to access and understand is integral. This approach should facilitate the release of staff from the current manual checks, to enable the interrogation of information, with additional focus on specific quality issues and improvement.

**Appendices -**

# St Andrew's Healthcare Integrated Quality Performance Report

reviewing the period ending June 2022

# 1) Quality Scorecard

**Quality Scorecard** at a Charity level there are special cause improvements across five quality indicators with no special cause concerns. Clinical targets have been agreed and are presented within this paper.

Charity Position

| Measure | Incident | | Violence | | Incident L1 | | Incident L2 | | Incident L3 | | SI | | Restraint | | Seclusion | | LTS | | LTS Days | | Rapid Tranq | | ES Episodes | | ES WTE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target |
| Divisions | | | | | | | | | | | | | | | | | | | | | | | | | | |

Divisions

| Measure | Incident | | Violence | | Incident L1 | | Incident L2 | | Incident L3 | | SI | | Restraint | | Seclusion | | LTS | | LTS Days | | Rapid Tranq | | ES Episodes | | ES WTE | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target |
| ASD & LD | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Birmingham | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CAMHS | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Partnerships | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Community Services | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Essex | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Low Secure & Specialist Rehab | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medium Secure | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Neuro | | | | | | | | | | | | | | | | | | | | | | | | | | |

ASDLD – recurring LTS concern is due to delayed transfers of care. Every effort is being made to secure appropriate settings for the inappropriately placed patients.

Community – all concerns relate to the deterioration of one service user who has responded well to their amended care plan. Incident levels have fallen as a result.

Neuro – increased utilisation of enhanced support reflects the changing profile of referred patients – with increasingly younger more physically able referrals. Clinical models and management plans are being refined in response.

Birmingham – increased scrutiny and focus on ensuring all incidents are recorded, combined with increased acuity has resulted in the concern being triggered. Clinical management of the acuity is appropriate.

Delayed transfers of care remain a challenge – notable for ASDLD. That said, the three patients, referred to in the prior report, who had turned 18 within the CAMHS service have all been successfully discharged.

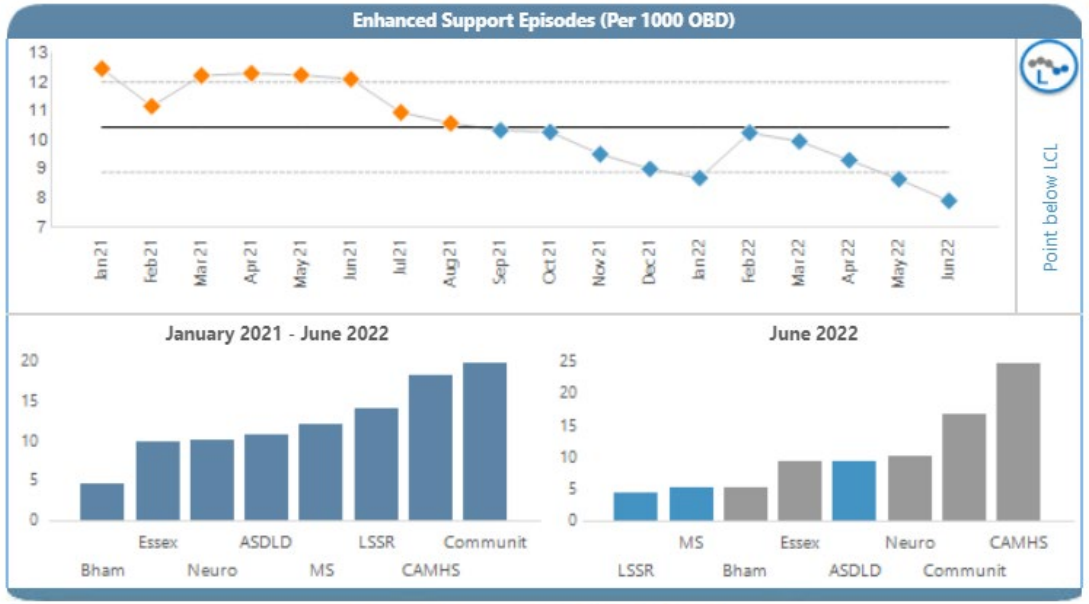
Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info

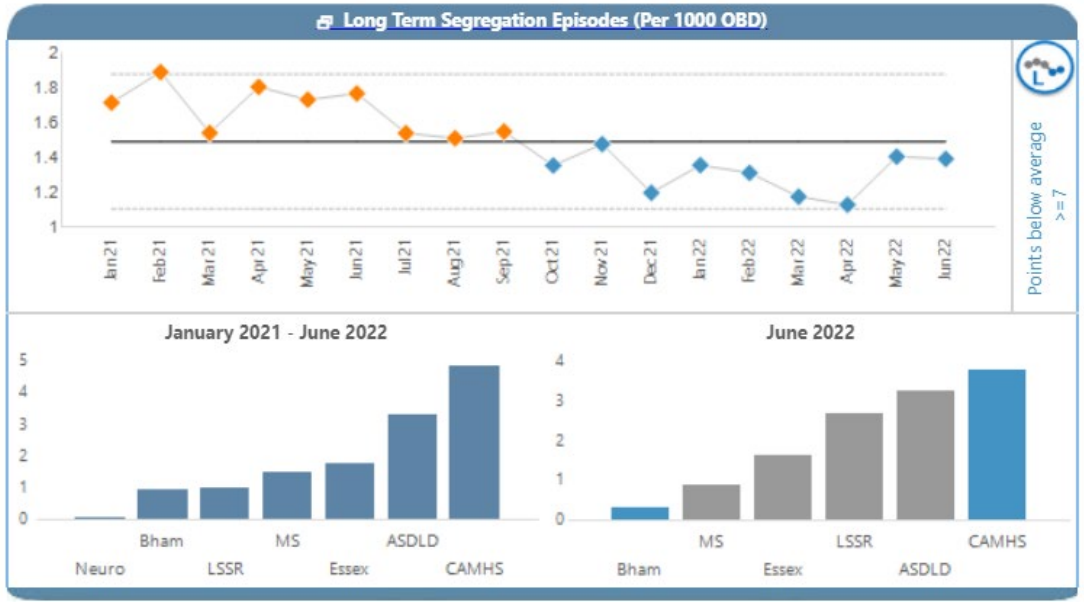
Concerns Improvements In Control

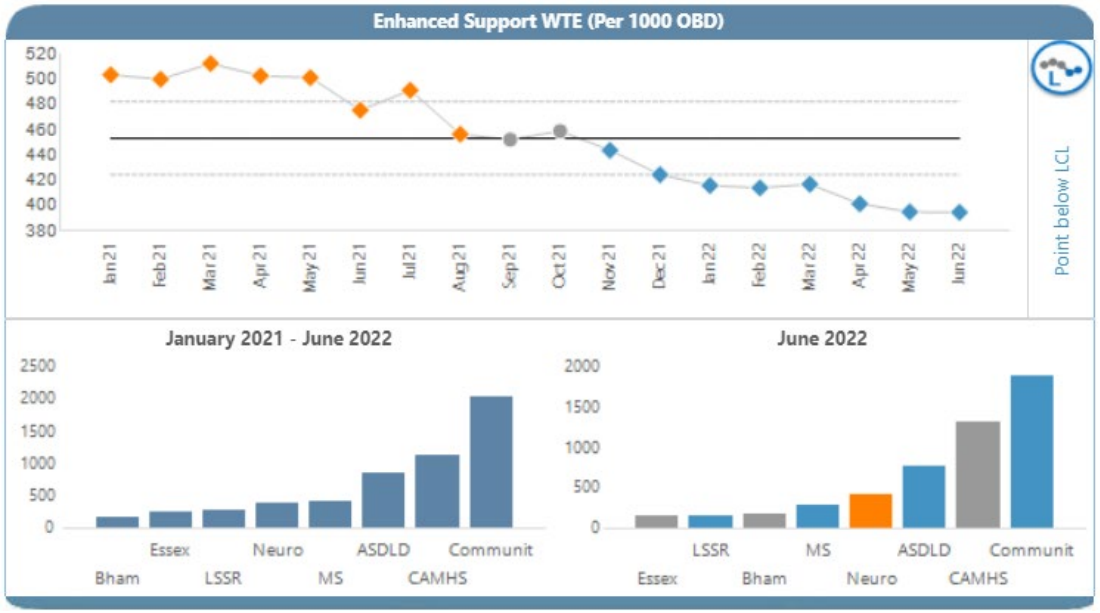
Trend lines are shown for KPIs with data volume too low for statistical significance

Concerns Improvements

# **Exception reporting** – Enhanced Support



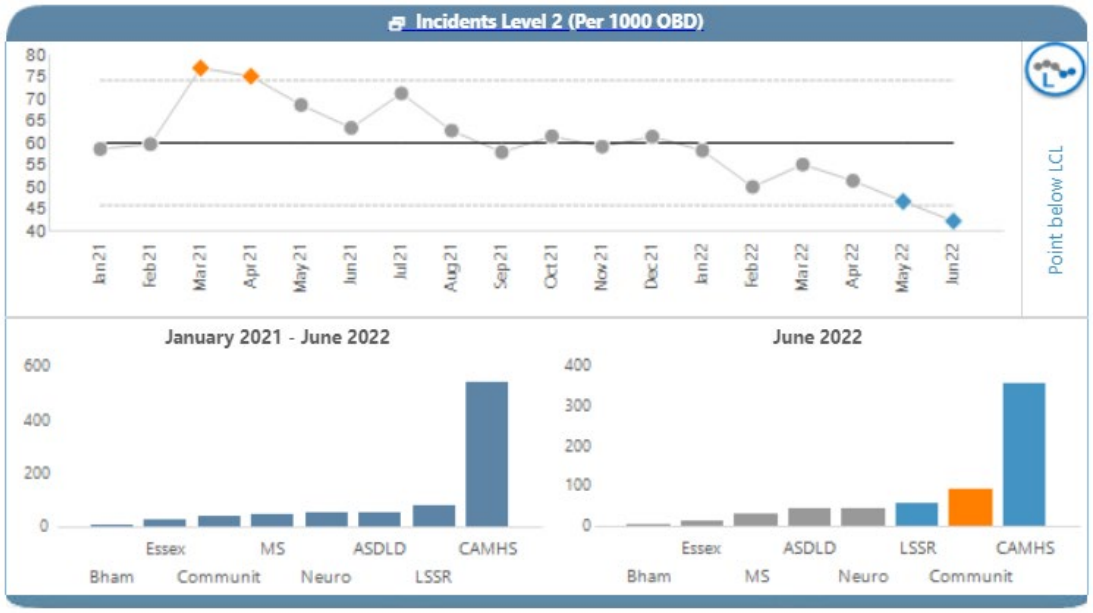



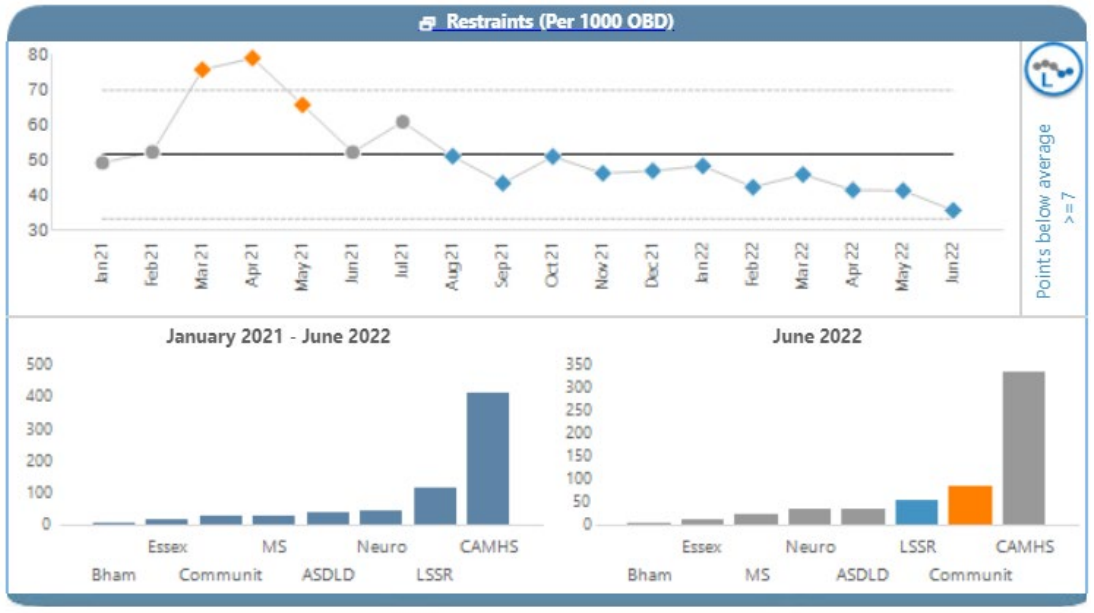

Sustained improvement - fewer new episodes of enhanced support, correlating with a reduction in the level of resource required. Special cause improvements for ES and LTS, initially reported to the Board in January, have been sustained. This reduction correlates with the REDUCE programme, alongside the sustained scrutiny of enhanced support.

Improvements

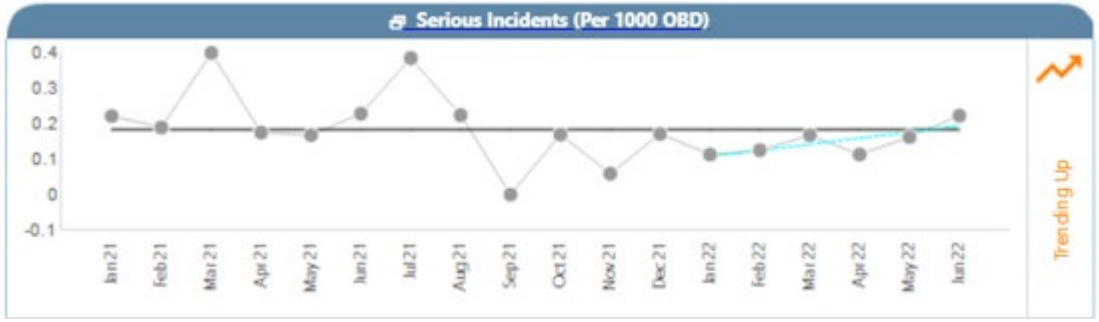
Concerns

# **Exception reporting** – Incident Level 2, SI & Restraint




Sustained special cause improvements for level 2 incidents and restraint. This reduction correlates with the REDUCE programme. Incidents of Violence – previously returned a sustained improvement, this metric is now within control limits, following an above control limit month for May. Overall incident levels and incident levels 1 & 3 are within control limits. Whilst SIs have seen a marginal increase the volume remains low and there is no apparent clustering. Analysis to be shared with QSC. Early learnings are being acted upon.



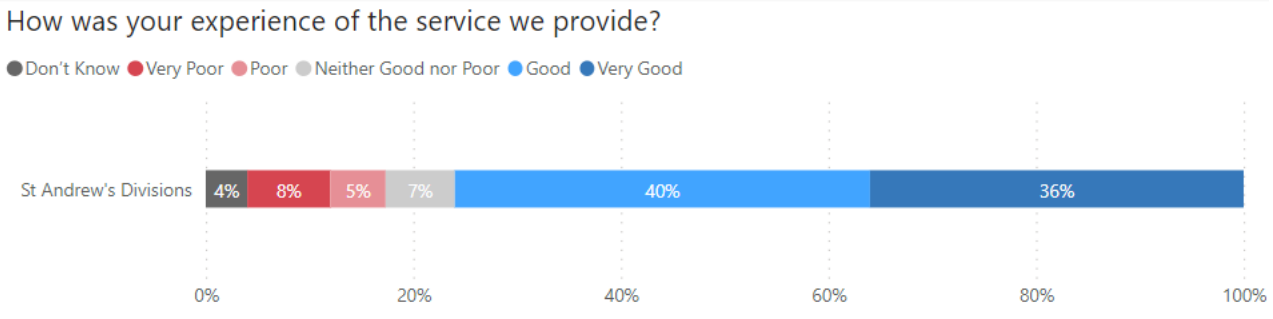
## Ward level assurance

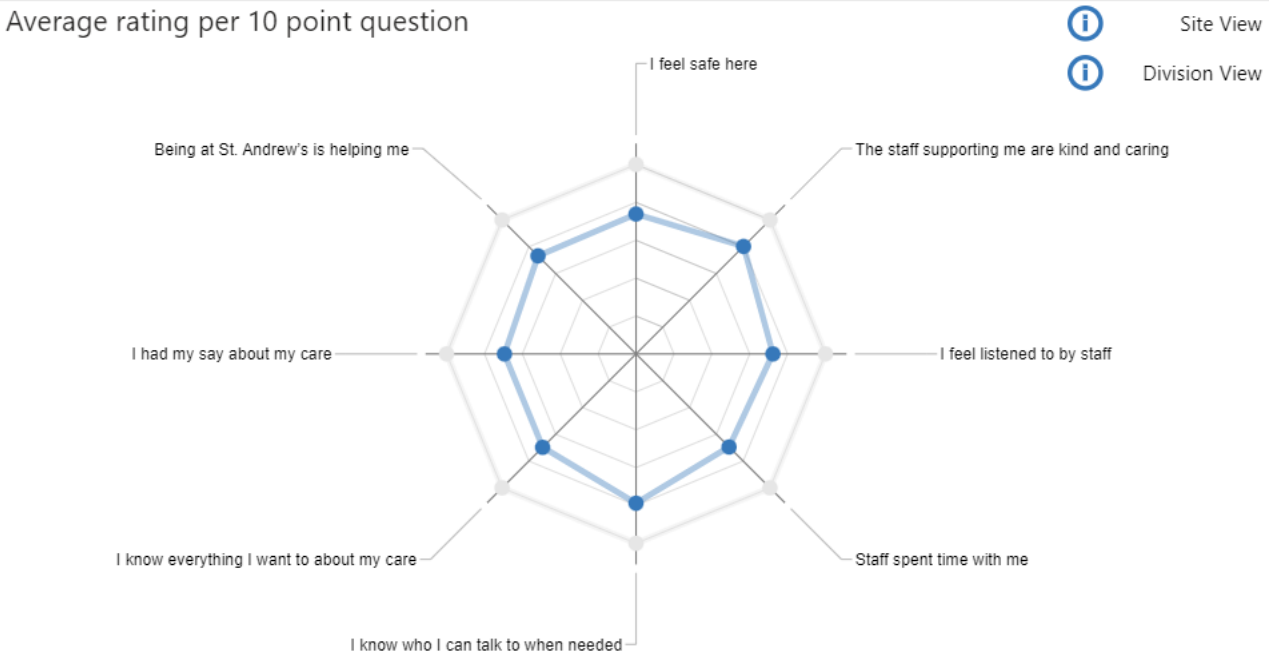
The quality scorecard presented in this report provides a Charity position alongside a disaggregated divisional view. The Quality & Safety Committee is provided with a further level of granularity in the form of the ward level quality scorecards, associated causal analysis and remedial actions. The below table represents a hybrid – providing an overview of the status, at ward level, of the 13 current quality KPIs (rapid tranquilisation has been added as a balance KPI following the introduction of targets). In summary 93% of the ward level quality KPIs are in control, have little or no data, or show a statistically insignificant trend, 4% show statistically significant improvements and less than 3% show statistically significant concerns (this is largely consistent with April 22).

| Division | Wards | SPC Concern | SPC Improvement | SPC Common Cause | Trend Concern | Trend Improvement | Little or No Data |
|---|---|---|---|---|---|---|---|
| ASD & LD | 14 | 5 % | 2 % | 29 % | 10 % | 10 % | 44 % |
| Birmingham | 8 | 3 % | 1 % | 12 % | 17 % | 10 % | 58 % |
| CAMHS | 4 | 8 % | 12 % | 25 % | 17 % | 12 % | 27 % |
| Community Services | 2 | 19 % | 0 % | 8 % | 4 % | 4 % | 65 % |
| Essex | 6 | 0 % | 4 % | 22 % | 6 % | 14 % | 54 % |
| Low Secure & Specialist Rehab | 9 | 0 % | 8 % | 16 % | 11 % | 15 % | 50 % |
| Medium Secure | 12 | 0 % | 6 % | 22 % | 8 % | 10 % | 54 % |
| Neuro | 12 | 5 % | 4 % | 28 % | 4 % | 6 % | 53 % |
| **Totals** | **67** | 3 % | **4 %** | **22 %** | 10 % | **10 %** | **50 %** |

Through the Integrated Quality and Performance reporting approach the Charity considers both SPC and trend concern themes at a metric level and reviews the distribution of concerns at ward level. Should a cluster of concerns be apparent at ward level the associated clinical plans are subject to check and challenge. This information is shared with the QSC for consideration. Leading indicators continue to be reviewed, there remains an open action for these to be incorporated into the IQPR matrix. There is current focus on further refining the utilisation of SPC graphs to identify potential emerging adverse trends that may result in an SPC concern. The Charity's new Quality Strategy, clinical governance and quality management approach are in the final stages of development and will be shared with the QSC and Board in the coming months.

# My Voice




The collated responses show 76% of respondents rate their experience as good or very good (65% May 2022). Overall response rates remain a concern, with inconsistent and insufficient completion levels. The Essex team have secured a strong volume of responses and their approach has been shared with colleagues for learning. Actions and learnings from My Voice will be included in ward, division and Charity wide QIPs. With lesson learnt being addressed via the dedicated Embedding lessons learnt into practice work stream (one of the nine work streams in the Improvement Programme).

# Clinical Targets

The Charity has set clinical targets within the spirt of the collective desire to continually improve the experience and outcomes of those we support. With this in mind, targets are bold and aspirational, aligned with our strategic ambition to **facilitate high quality person centred outcomes and experiences.**

The approach to developing these targets has been benchmarked with our NHS buddy organisation and draws on national targets, as agreed in the Mental Health Safety Improvement Programme (MHSIP - for which St Andrew's chair the East Midlands Alliance). In line with the MHSIP the Charity has set a 25% reduction target over 24months for key restrictive practices. The Charity has segmented the achievement across the four six month periods (6.25% reduction per period). The measure of success will be the 6month mean versus the targeted reduction at the end of each 6mths.

The below table demonstrates the 18mth mean baseline, per 1,000 occupied bed days as at end of June 22, the closing target as at June 24 and the closing target for the first 6mth interval. Based on current performance (6mth mean to June 22) the areas that are likely to require greater focus to achieve the interim target are: Incident L3, Seclusion and LTS days. The targets performing well align with the special cause improvements noted above. The progress to target will be shared with QSC with updates to the Board following the close of each 6mth interval.

| Measure | Baseline | Jun-24 Target | Dec-22 Target |
|---|---|---|---|
| Incident L3* | 8.37 | 6.28 | 7.85 |
| Restraint | 51.47 | 38.6 | 48.25 |
| Seclusion | 6.57 | 4.93 | 6.16 |
| Seclusion Hours | 238.21 | 178.66 | 223.32 |
| LTS Episodes | 1.49 | 1.12 | 1.40 |
| LTS Days | 32.57 | 24.43 | 30.54 |
| Rapid Tranq | 8.47 | 6.35 | 7.94 |

* Incident reporting systems have been improved, alongside this the Charity has been working with it's staff to align their understanding of the harm levels, with the nationally recognised Patient Safety Framework definition. This should be taken into account, given the 18mth mean presented as the baseline.

# 2) People Scorecard

# **People Scorecard** at a Charity level: training, agency spend and sickness are favourable to target. The remaining metrics are adverse to target.

## Charity Position

| Measure | Vol Turnover | | Vol Turnover Month | | RN Ratio | | HCA Ratio | | Training | | Agency Spend | | Sickness % | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target |
| Divisions | | | | | | | | | | | | | | |
| StAndrews | | | | | | | | | | | | | | |

## Divisions

| Measure | Vol Turnover | | Vol Turnover Month | | RN Ratio | | HCA Ratio | | Training | | Agency Spend | | Sickness % | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target |
| ASD & LD | | | | | | | | | | | | | | |
| Birmingham | | | | | | | | | | | | | | |
| CAMHS | | | | | | | | | | | | | | |
| Community Partnerships | | | | | | | | | | | | | | |
| Community Services | | | | | | | | | | | | | | |
| Essex | | | | | | | | | | | | | | |
| Low Secure & Specialist Rehab | | | | | | | | | | | | | | |
| Medium Secure | | | | | | | | | | | | | | |
| Neuro | | | | | | | | | | | | | | |

As a key enabler for quality, a driver for employee experience and financial results, there is a considerable focus on improving the performance of workforce metrics. Divisions are adverse to all workforce targets, with the exception of agency spend. Recovery plans continue to be developed and refined. Likely rectification timeframes are being secured. In most instances, the complexity of underlying root cause, results in tiered plans that will take time to bring metrics in line with thresholds.

Despite population levels of COVID rising, sickness at a Charity level has moved to within target.

Improved analytics and insight remain underdevelopment due to capacity being focused on Allocate.

| Measure | Vol Turnover | | Vol Turnover Month | | Training | | Agency Spend | | Sickness % | |
|---|---|---|---|---|---|---|---|---|---|---|
| - | SPC | Target | SPC | Target | SPC | Target | SPC | Target | SPC | Target |
| Functions | | | | | | | | | | |

*Please note as CAMHS are a smaller division they may be disproportionately impacted by a small number of staff members

Statistical Process Control (SPC) rule trigger icons. Hover over icon for more info
Concerns Improvements In Control

Trend lines used for KPIs with data volume too low for statistical significance
Concerns Improvements Stable

Target icons show if KPIs are passing or failing
Passing Failing

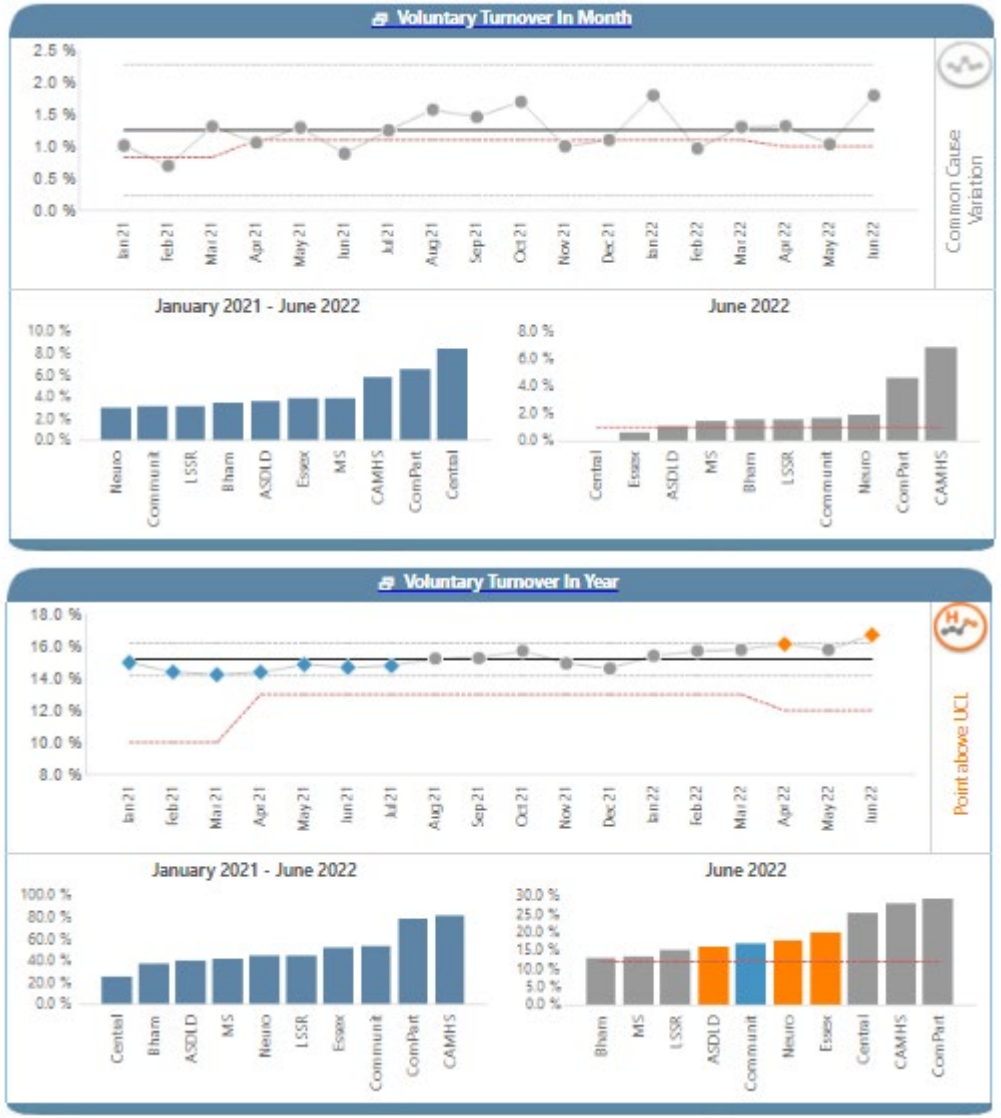
No icon shown if the KPI has little or no data in the last 6 months

v1.08

Concerns

# **Exception reporting** –Voluntary Turnover in Year & Month

## Divisions




At Charity level the June voluntary turnover was adverse to target at 1.40% (divisions returned 1.71%* with enabling functions at 0.62%).

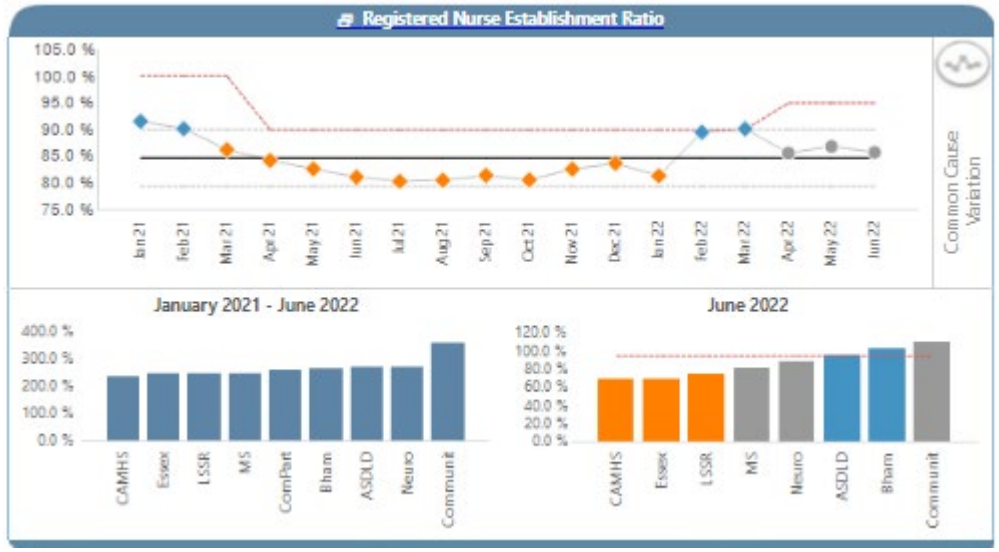

The Charity level waterfall chart shows a marginal increase in total staff – this is due to increases in enabling functions rather than in divisions. This correlates with the adverse to target and above control limit voluntary turnover for divisions. The average tenure of voluntary leavers was 4.7 years, 15 individuals left in the first 12 months. The top two reasons for leaving in June were better package and work life balance.

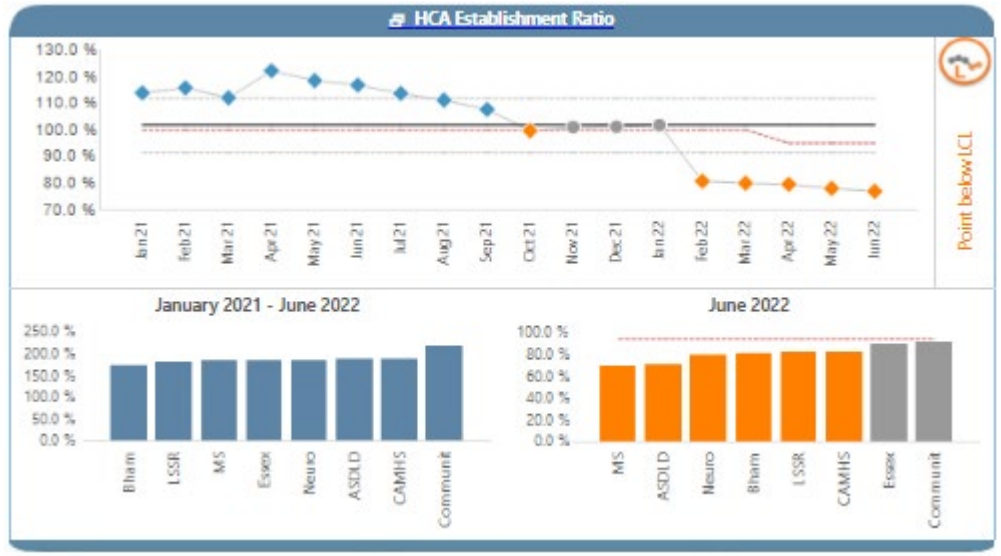
**Retention Initiatives** - there are a number of initiatives in place that will aid retention, including the Lead the Change culture programme, local your voice action plans, refreshed division specific retention plans, the roll out of Allocate (e-rostering) and offering more flexible shifts, the increase to pay the Real Living Wage (and next steps of pay progression for critical roles), talent management, career development support, the introduction of stay conversations and further support on wellbeing.

*excluding transfers to WorkChoice. BI development work pending to include these as turnover.

Concerns

# **Exception reporting** – Establishment ratio (permanent staff) adverse to target




As at the end of June the RN establishment stood at 86% and HCAs at 77% (April: RN 86%, HCA 79%).

The national and local deficit of nurses continues to present as a hugely challenging recruitment market. Further hampered by significant local competition across all £18k-£24k role types. This combined with the adverse to target turnover has resulted in a largely neutral establishment position. On this basis recruitment projections are being refreshed and will incorporate updates, as applicable, from the MHOST review. The reforecast will be shared at the August People Committee.

**Actions to achieve the projection:**

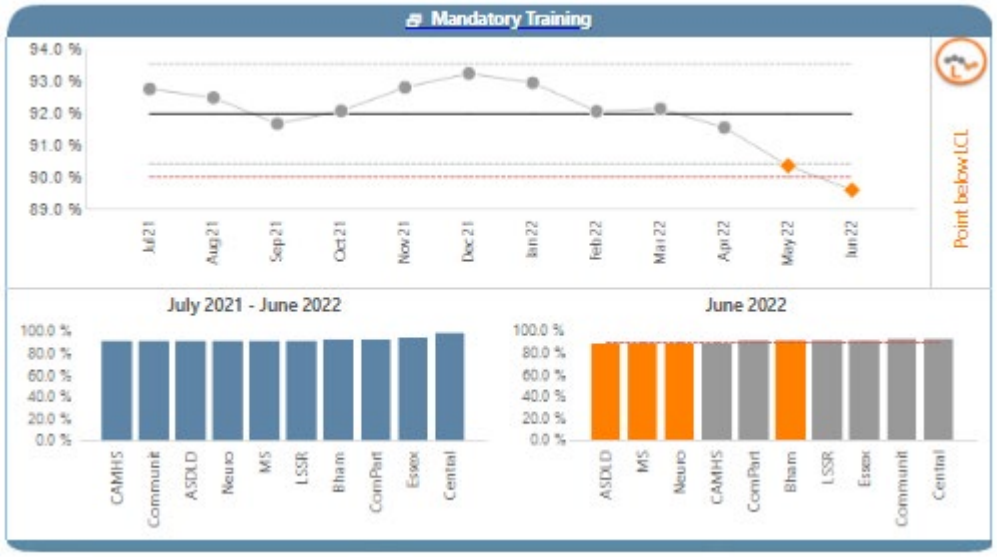
- Significant recruitment activity - including international recruitment
- Regular WorkChoice converted to substantive flexible contracts
- Advertising all posts as part time / flexible to increase potential candidate pools (this approach is continuing to have an impact - WTE of HCAs as at April averaged 0.95, WTE of HCA new starters for June averages 0.72 – the unintended consequence is increased recruitment effort to secure comparable WTE)
- Securing the retention initiatives will bring forward the trajectory for target establishment achievement

*the SPC for HCAs is pending rebasing due to the change in establishment methodology

# **Exception reporting** – Mandatory Training

## Charity wide


## Divisions

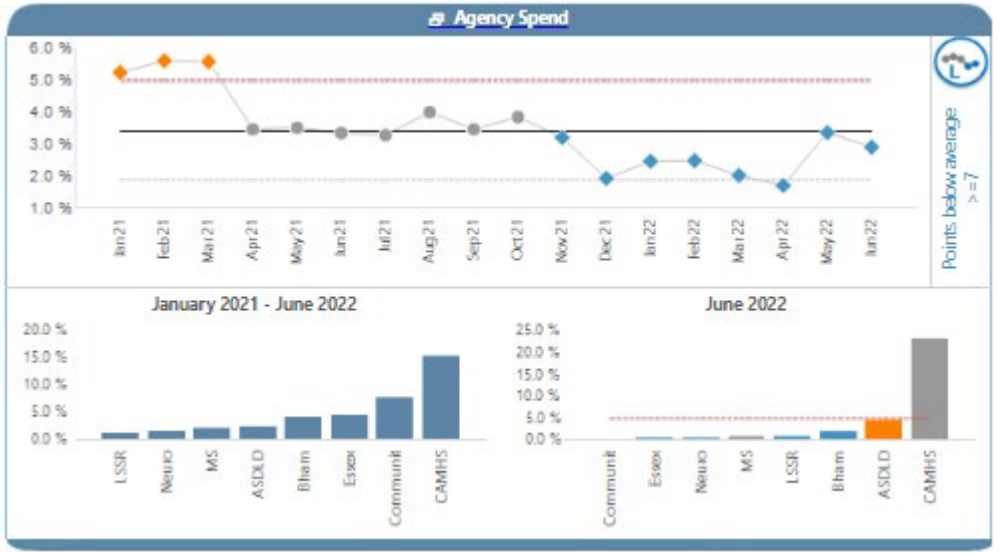



Training is marginally favourable to target at a Charity level at 90.45%. At both a Charity and a division there are SPC level concerns due to the lower control limits being breached.

CAMHS have joined Medium Secure, Neuro and ASDLD marginally below the threshold, all between 88-89%. Ward staffing levels have continued to restrict the number of staff available to be released for training. The focus on recruitment and retention of ward based clinical roles will, in time, ease the current challenges. This combined with improved scheduling via Allocate and the re-introduction of block mandatory training (at staff and management request) with aid utilisation. The Charity is seeking additional innovative solutions to reverse the trend for the volume of staff trained in BLS 72% and SIT 76% (April: BLS 79%, SIT 84%) and increasing Safeguarding Level 3 from 86% to target. ILS stands at 95%.

The Charity's training levels continue to benchmark favourably.

# **Exception reporting** – Agency Spend

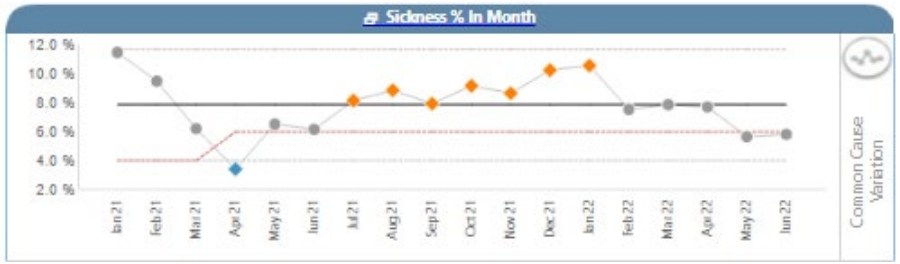



Charity wide agency spend is 2.90% (1.75% April) and remains low. All divisions are below the tolerance except CAMHS at 23.39% - this reflects planned and consistent agency utilisation in order to mitigate a period of under establishment, with new permanent starters due to arrive in July.

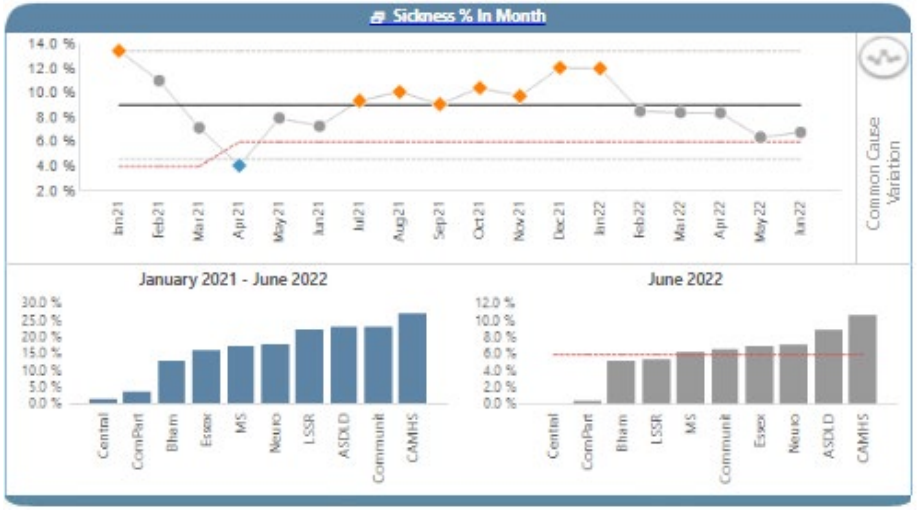
The current levels reflect a lack of availability of agency staff and a highly competitive marketplace. That Charity has increased rates and introduced CAMHS specific incentives in order to secure provision. The Charity continues to work closely with agencies with the intention of increasing supply for specific wards to support staffing, corresponding with the increase in ASDLD.

# **Exception reporting** – Sickness

## Charity wide




## Divisions




Despite the increasing levels of COVID in the population, sickness has decreased, with the June Charity wide position favourable to target at 5.82%* - equating to 24,291 hours of working time, at a cost of £325k (£221k for wards). Enabling Functions have seen the largest fall from 5.9% in April to 3.72% in June. Divisions have reduced less markedly - 7.8% to 6.78%. Despite the positive reduction in long term absence cases (69 to 57), divisional sickness is adverse to target and when combined with the above expectation volume of non-patient facing shifts (analysis to be routinely shared with People Committee), continues to have a significant impact on ward staffing. It is anticipated that sickness will increase in future months, unless COVID prevalence declines.

**Remedial actions:**

- The Absence project continues to have a priority focus on reducing sickness absence – the solutions will take time to deploy and embed. They include optimising the improved functionality in Allocate and supporting managers to consistently secure high quality people management
- The employee relations team are providing central management for long term sickness cases
- Enhanced IPC measurers reintroduced
- A continued focus on wellbeing supporting colleagues to stay well

# Finance Overview

# Financial Performance 2022/23

**June 2022 Actual Performance v Budget**

- **Net deficit £2.1m - £0.56m lower than budget. Operating Deficit £0.16m lower than budget**
- In Qtr1 2022 we saw an increase in avg occupancy of 5% (circa 29 patients)
- However, occupancy was slightly behind plan (mainly due to external factors and self-imposed admissions to the CAHMS Division) **with 97.6% achievement of budgeted income**.
- **Offset by positive movement in costs of £1.1m** (£0.9m Operational & £0.2m Overheads)
- Additional £0.4m of lower project costs due to timing of actual expenditure compared to budget assumption.
- At June 2022 cash held was £5.1m (**£1m more than budget**) and no covenant risk existed

**Full Year Outlook Performance v Budget**

- Exec expect similar trends to continue. **Shortfall in income but offset by costs and budgeted net deficit achieved.**
- Occupancy growth, controlling ward staffing costs inline with budget, inflation and reduction in investment portfolio valuation (linked to stock markets) remain the main risks to achieving the 2022/23 budget.
- Cash and covenants are expected to track inline with budget.
- More detail within Private Board Reports

| | June 22 YTD | | | Full Year |
|---|---|---|---|---|
| **Financial Performance - £m** | **Actual** | **Budget** | **Variance** | **Budget** |
| Income | 40.98 | 42.08 | (1.09) | 176.08 |
| Direct & Indirect Costs | (31.33) | (32.26) | 0.94 | (130.41) |
| **Net Contribution** | **9.66** | **9.81** | **(0.15)** | **45.67** |
| Enabling Services | (8.21) | (8.39) | 0.18 | (31.88) |
| Depreciation | (2.81) | (2.94) | 0.13 | (11.26) |
| **Operating Surplus/(Deficit)** | **(1.36)** | **(1.52)** | **0.16** | **2.53** |
| Non Operating Costs | (0.11) | (0.10) | (0.00) | (0.37) |
| Exceptional Costs | (0.29) | (0.32) | 0.03 | (1.00) |
| Disposal of Fixed Assets & Impairment | 0.00 | 0.00 | 0.00 | (0.25) |
| Project Costs - OPEX | (0.41) | (0.79) | 0.38 | (3.33) |
| Investment Gains/Losses | 0.00 | 0.00 | 0.00 | 0.00 |
| **Net Surplus/(Deficit)** | **(2.17)** | **(2.74)** | **0.57** | **(2.42)** |

# Balance Sheet & Cashflow

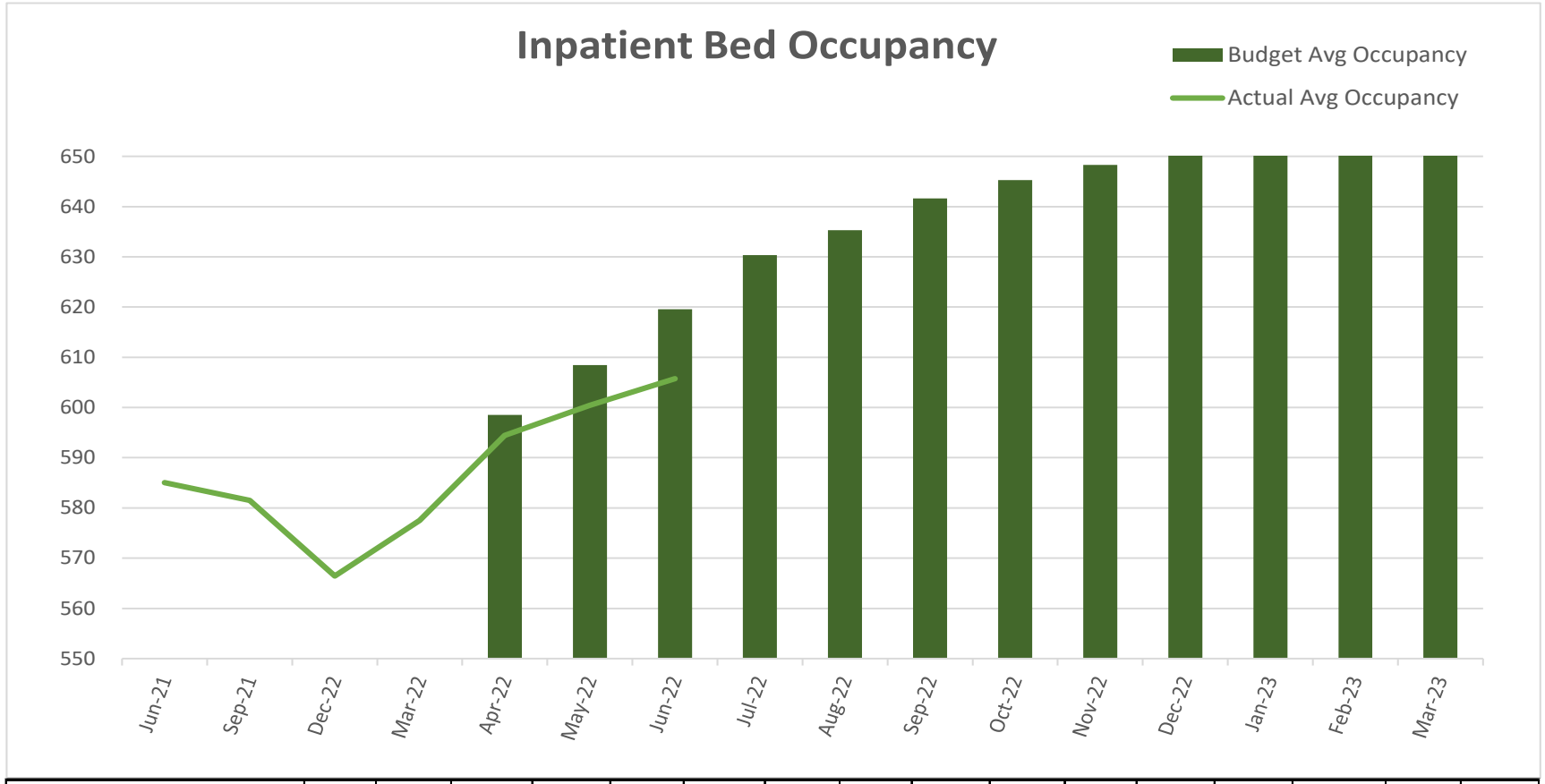
| St Andrew's Consolidated Balance | Mar-21 Audited | Jun-21 Actual | Sep-21 Actual | Dec-21 Actual | Mar-22 Actual | Jun-22 Actual |
|---|---|---|---|---|---|---|
| | £M | £M | £M | £M | £M | £M |
| **Intangible and tangible fixed assets** | 209.0 | 205.9 | 203.3 | 198.2 | 196.6 | 193.9 |
| **Investments** | | | | | | |
| Stock Market Investments | 15.7 | 15.8 | 15.9 | 17.6 | 11.6 | 11.7 |
| Investment Properties | 5.7 | 5.7 | 5.7 | 5.7 | 5.7 | 5.7 |
| **Current Assets** | | | | | | |
| Stock | 0.6 | 0.5 | 0.4 | 0.5 | 0.4 | 0.5 |
| Trade debtors | 7.3 | 10.4 | 9.0 | 9.6 | 8.2 | 9.4 |
| Other Debtors & Accrued Income | 5.2 | 5.6 | 6.1 | 4.4 | 4.1 | 4.4 |
| Prepayments | 1.7 | 1.3 | 1.6 | 2.0 | 1.8 | 1.2 |
| Cash | 5.8 | 4.1 | 4.5 | 5.8 | 6.0 | 5.1 |
| | **20.6** | **21.9** | **21.6** | **22.3** | **20.5** | **20.6** |
| **Current Liabilities** | | | | | | |
| Trade Creditors | (7.6) | (4.9) | (3.8) | (2.8) | (3.3) | (3.7) |
| Taxation and Social Security | (3.1) | (3.4) | (3.6) | (2.8) | (2.8) | (3.3) |
| Other Creditors & Accruals | (8.5) | (8.6) | (9.0) | (8.6) | (8.3) | (8.3) |
| Staff Accruals | (4.0) | (3.3) | (3.6) | (4.4) | (4.4) | (3.5) |
| Deferred Income | (2.5) | (2.7) | (3.5) | (4.3) | (2.5) | (2.3) |
| | **(25.7)** | **(22.9)** | **(23.5)** | **(22.9)** | **(21.4)** | **(21.0)** |
| **Net Current Assets/(Liabilities)** | **(5.2)** | **(1.0)** | **(2.0)** | **(0.5)** | **(0.8)** | **(0.4)** |
| **Total Assets Less Current Liabilities** | **225.2** | **226.4** | **223.0** | **221.0** | **213.1** | **210.9** |
| **Bank Loans (between 1 and 5 years)** | (19.8) | (24.8) | (24.9) | (24.9) | (20.0) | (20.0) |
| **Pension Scheme Liability** | (0.7) | (0.7) | (0.7) | (0.7) | (0.7) | (0.7) |
| **Total Assets Employed** | **204.7** | **200.9** | **197.4** | **195.4** | **192.4** | **190.2** |
| **Reserves** | **204.7** | **200.9** | **197.4** | **195.4** | **192.4** | **190.2** |

| Cashflow Summary - £m | June 22 YTD Actual | Budget | Variance | Full Year Budget |
|---|---|---|---|---|
| Net Surplus/(Deficit) | (2.2) | (2.7) | 0.6 | (2.4) |
| **Add Back Non Cash Items** | | | | |
| Depreciation | 2.8 | 2.9 | (0.1) | 11.3 |
| Fixed Asset Impairment/(Profit on Disposal) | 0.0 | 0.0 | 0.0 | 0.3 |
| Investment Portfolio Valuation Movement | (0.0) | 0.0 | (0.0) | 0.0 |
| **Net inflow/(outflow) from Operations** | **0.6** | **0.2** | **0.4** | **9.1** |
| Total inflow/(outflow) - Working Capital | (1.2) | (0.8) | (0.5) | (0.4) |
| Total inflow/(outflow) - Capital Expenditure | (0.2) | (1.3) | 1.1 | (5.9) |
| Total inflow/(outflow) - Asset Disposal | 0.0 | 0.0 | 0.0 | 0.6 |
| Total inflow/(outflow) - Investment Portfolio | 0.0 | 0.0 | 0.0 | 0.0 |
| Total inflow/(outflow) - Loan Facility | 0.0 | 0.0 | 0.0 | (5.5) |
| **Net Cash (Outflows) / Inflow** | **(0.9)** | **(1.8)** | **1.0** | **(2.1)** |
| **Cash at the 31.3.2022** | **6.0** | **6.0** | **0.0** | **6.0** |
| Total Cashflow Movement | (0.9) | (1.8) | 1.0 | (2.1) |
| **Cash at the end of the period** | **5.1** | **4.2** | **1.0** | **3.9** |

| Net Debt - £m | June 22 YTD Actual | Budget | Variance | Full Year Budget |
|---|---|---|---|---|
| Cash Held | 5.1 | 4.2 | 1.0 | 3.9 |
| Bank Loan Balance | (20.0) | (20.0) | 0.0 | (20.0) |
| Investment Balance | 11.7 | 11.6 | 0.1 | 11.6 |
| **Net Debt** | **(3.2)** | **(4.2)** | **1.1** | **(4.5)** |
| Credit Facility | 27.0 | 27.0 | 0.0 | 27.0 |
| Credit Facility Headroom | 7.0 | 7.0 | 0.0 | 7.0 |

CAPEX & Working Capital movement are timing variations compared to budget assumptions. Not an area of concern.

# Occupancy




| | Jun-21 | Sep-21 | Dec-22 | Mar-22 | Apr-22 | May-22 | Jun-22 | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | Jan-23 | Feb-23 | Mar-23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Budget Avg Occupancy | | | | | 599 | 608 | 620 | 630 | 635 | 642 | 645 | 648 | 651 | 658 | 658 | 658 |
| Actual Avg Occupancy Funded | 585 | 582 | 566 | 577 | 594 | 600 | 606 | | | | | | | | | |
| Actual % Achievement | | | | | 99.3% | 98.7% | 97.8% | | | | | | | | | |

# IT Security overview

# IT Security Metrics (Apr – June 2022)

| Legend | No Change | Trending Down | Trending Up |
|---|---|---|---|

| | APR | MAY | JUN | RAG Rating | June – *Causal* | June – Remediation |
|---|---|---|---|---|---|---|
| **Vulnerabilities not fixed within SLA**<br>Highlights the amount of infrastructure vulnerabilities that haven't been fixed within the agreed timescales | 0 | 0 | 0 | | **Causal Analysis**: Vulnerabilities are actively tracked to ensure compliance, any breaches in terms of SLA's are either presented for risk acceptance or dispensated to investigate a fix. | **Remedial Actions:** IT Security and Advanced will continue to monitor and track SLA breaches and raise any Non-Conformances if required. |
| **Overdue Penetration Test Remediation**<br>The last Pen test for the Charity was in July 2021. This highlights how many findings are overdue. | 0 | 0 | 0 | | **Causal Analysis**: No overdue actions again this month. Network Segregation Penetration Test currently in scope, to be conducted by Bulletproof in June. | **Remedial Actions:** None |
| **Security Incidents**<br>Trend of Priority 1, Priority 2 and Priority 3 incidents | P1 0<br>P2 1<br>P3 4 | P1 0<br>P2 0<br>P3 2 | P1 1<br>P2 1<br>P3 2 | | **Causal Analysis**: All incidents were related to phishing emails reported. The P2 was a clicked malicious link but credentials were not submitted. The P1 was a fake invoice within a .html attachment, which was received by 102 users. There were multiple clickers over the weekend, and all passwords were reset. | **Remedial Actions:** IT Security are reviewing the current phishing awareness methods as a multi-pronged approach is required. 1:1 conversations with staff who click on links have been implemented to provide more targeted awareness as well. |
| **Blocked Network Attacks**<br>These are blocked network attacks directed at our external network edge | 34907 | 41957 | 22584 | | **Causal Analysis**: We are constantly being port scanned and probed by external threat actors. Our firewall is configured to block this traffic. Russian IPs are automatically dropped and blocked at the firewall. | **Remedial Actions:** Enhanced monitoring owing to the ongoing war in Ukraine and the increased cyber risk to the west. |
| **Overdue IT Sec Audit Actions**<br>Number audit actions and their rating from scheduled internal and external audits. | 0 | 0 | 0 | | **Causal Analysis**: Updates have been provided with some actions closed. | **Remedial Actions:** Regular catch ups are conducted with action owners. ISO27001 meetings are conducted on a weekly basis with all Managers to track actions. |
| **Outstanding Operating System Patches**<br>% of devices patched across the infrastructure. Separated into server and endpoint estate | Servers = 92.07%<br>Client = 94.16% | Servers = 93.39%<br>Client = 96.25% | Servers = 93.39%<br>Client = 96.25% | | **Causal Analysis**: An average tolerance of 16% each month is expected as ~300 devices take longer to check in & update during the 4-week patching window (holiday, sickness, network speed, etc). Client devices are all built to a government secure industry standard, have anti-malware installed, are protected by the web filter even off the network and have firewalls enabled | **Remedial Actions:** The patching process for client devices is due to be reviewed with more staff working remotely or not being based in an office which causes some delays e.g. Community Partnerships. |
| **Anti-Malware Installation Compliance**<br>% of machines on the network that have anti-malware protection installed and enabled | 100% | 100% | 100% | | **Causal Analysis**: None | **Remedial Actions:** None |
| **Blocked Attacks on Staff Accounts**<br>Attempted logins from malicious actors to staff accounts. These aren't successful and are flagged by our SIEM tool | 12 | 3 | Due to the recent SIEM upgrade, the collection of these statistics is on hold until the new setup is complete. | | **Causal Analysis**: Attackers perform password attacks against accounts they find on LinkedIn or through other means. They will use 1000s of common passwords through automated tools. Finance is the most targeted department per ratio of 100 staff | **Remedial Actions:** IT Security monitor these on a daily basis and will investigate to ensure they are not successful. High risk departments have Multi-Factor Authentication enabled e.g. Finance, HR, IT, Estates. |
| **Security Awareness**<br>% of applicable staff who have completed their e-learning module on cyber security & information governance | 90% | 89% | 89% | | **Causal Analysis:** L&D are seeing challenges in staff booking and being released to attend training with the current staffing challenges. Not at the required level of 95% for the Data Security & Protection Toolkit. | **Remedial Actions:** IT Sec have revised the training. L&D are reviewing with Info Gov. |

# Navigating St Andrew's SPC charts



**Target line**

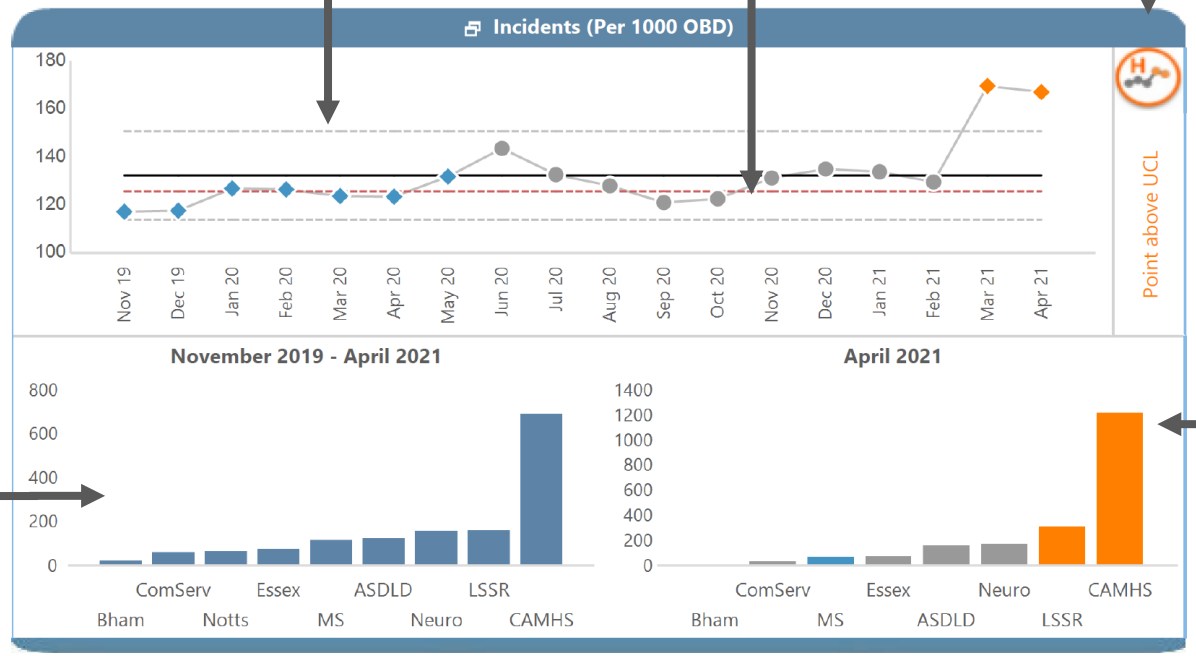
Proposed target for the KPI

**SPC icon for the latest month**

**Orange icon** = Special cause concern
**Blue icon** = Special cause improvement
**Grey icon** = Common cause variation
**Trend line** = Not enough data for statistical significance. Icon replaced by trend line.

**Charity level SPC chart**

Shows the trend for the last 18 months as a per 1000 occupied bed days rate




**Division average for the last 18 months**

Helps understand how the last 18 months compare to the latest month

**Latest month by Division**

Shows how Divisions are contributing to the overall charity level in the SPC chart above.

The bar colour illustrates if a Division itself has an SPC concern/improvement

**Example Narrative**

April 2021 shows an SPC special cause concern as the data point is above the Upper Control Limit.

The latest month Division chart shows that CAMHS and LSSR are high contributors, with both triggering an SPC special cause concern in their own data. Although their high contribution is in line with the last 18 months trend, the latest month rate is much higher.

Whilst the charity position is concerning, MS is showing special cause improvement for April 2021.

# Divisional Presentation (inc Patient Voice)

Birmingham

Kerry-Ann Chinn & Patient
By Video

# Paper for Board of Directors

| | |
|---|---|
| **Topic** | Divisional Presentations – looking ahead |
| **Date of Meeting** | Tuesday, 26 July 2022 |
| **Agenda Item** | **15** |
| **Author** | Duncan Long, Company Secretary |
| **Responsible Executive** | Dr Sanjith Kamath, Executive Medical Director |
| **Discussed at Previous Board Meeting** | Agenda item at all Board of Directors meeting |
| **Patient and Carer Involvement** | Not specifically for the update. |
| **Staff Involvement** | Not specifically for the update. |
| **Report Purpose** | Review and comment ☒<br>Information ☐<br>Decision or Approval ☐<br>Assurance ☐ |
| **Key Lines Of Enquiry:** | **S** ☐ **E** ☐ **C** ☐ **R** ☐ **W** ☐ |
| **Strategic Priority Area** | Education and Training ☒<br>Finance & Sustainability ☒<br>Service Innovation ☒<br>Quality ☒<br>Research & Innovation ☒<br>Workforce, Resilience & Agility ☒<br>Partnerships & Promotion ☒ |
| **Committee meetings where this item has been considered** | None specifically for this update |

**Report Summary and Key Points to Note**

The purpose of this paper is to provide the Board with the opportunity to discuss the Divisional Presentation and Patient Voice agenda item and to consider how these items may be included in future agendas.

The Divisional Presentation, to include the Patient Voice was added to the Board agendas (now within the Public element) in July 2020 and since that time the majority of the Divisions have been represented, with either patients or carers in attendance, or at least involved in the presentations or pre-recorded videos.

Having covered all divisions in some form or another, the Board is asked to consider in what format and frequency these type of divisional updates and patient voice items should be moving forward.

**Appendices - None**

# Divisional Presentation – looking ahead

## Introduction

The Board has historically received presentations from services and some of these have included patient involvement. In 2018, the Patient Voice item started being added to agendas, whereupon the Board would receive either presentations or videos by patients, or patients would be in attendance to have specific discussions. Many of the patient voice agenda items at this time however were updates on the Complaints and Complements being seen at the time or were updates on the Patient Engagement function and did not include actual patient involvement or updates on what services were doing. These areas are now presented and discussed at both the Quality and Safety Committee or People Committee.

The Divisional Presentation, to include the Patient Voice was added to the Board agendas (now within the Public element) in July 2020 and since that time the majority of the Divisions have been represented, with either patients or carers in attendance, or at least involved in the presentations or pre-recorded videos.

Having covered all divisions in some form or another, the Board is asked to consider in what format these type of divisional updates and patient voice items should be moving forward.

## Divisional Presentations and Patient Voice items:

As a reminder, the following sessions have been included in Board agendas over the last two years:

July 2020 – A patient led presentation on Acute Disseminated Encephalomyelitis (ADEM), including a Q&A discussion on patient life within St Andrew's.

September 2020 – CAMHS presentation, with patients and staff discussing the move to Smyth House from FitzRoy.

November 2020 – Presentation and discussion from a patient who recently transferred from the closed Mansfield Hospital and moved to FitzRoy House in Northampton.

January 2021 – Divisional led presentation on Community Partnerships, outlining the different services offered by the division (presented as a short notice stand-in due to the previously planned patient led session being withdrawn with short notice)

March 2021 – Blended ward presentation by patient, supported by divisional staff.

May 2021 – Essex presentation by Hospital Director and staff focussing on Occupational Therapy, with slides prepared by patients (who were unable to attend on the day).

August 2021 – Sycamore model of care (medium secure) presentation prepared by a patient, but presented by divisional staff as the patient was unable to attend on the morning.

September 2021 – Co-produced and co-presented presentation and Q&A with a patient from 23a The Avenue (Deaf Service), involving patient, BSL Interpreter and Divisional staff.

November 2021 – Co-produced and co-presented presentation from the Low Secure and Specialist Rehab (LSSR) division focussing on their tailored induction course that is run for staff, carers and patients. Introduced and led by a patient, supported by divisional staff.

January 2022 – Divisional led presentation from Neuropsychiatry, focussing on carer engagement and co-presented by parents of a former patient who shared their views and experiences, along with a Q&A session.

March 2022 – Divisional led presentation by the Nurse Manager of Bracken Ward (Women's Services) that included patient involvement in writing the presentation, focussing on how co-production had positively impacted blanket restrictions, reduced incidents and demonstrated therapeutic based recovery.

May 2022 – Divisional led presentation on Community Partnerships, outlining the progress within the division as requested by Board following the previous presentation in January 2021.

July 2022 – Birmingham presentation by Hospital Director.

One of the challenges of this section is the availability of the patients. On a number of occasions the patients who have prepared the presentations or videos, are themselves unable to attend on the day. This may be due to issues with their leave status, or how they are presenting on the day and their wish not to be involved. One issue raised by a number of patients was the session was too early for them. Whilst the patient voice section was included at the beginning of the agenda, following a practice seen within NHS Trusts, so that the patients would not be potentially impacted by an overrunning agenda, the slot was moved to the end of the public meeting session and steps taken to ensure it commences on time. Unfortunately there remain occasions when the patient/s decide on the day not to attend or be involved, irrespective of the time.

## Conclusion:

The Divisional Updates and Patient Voice items are an essential addition to the Board meetings in public and provide the Board with insight into both divisional and patient experiences in addition to the Quality Deep Dives in these areas seen at each Quality and Safety Committee. There has been a varied selection of presentations and discussions since the item was added to the Board agenda, however it is evident that in-person patient involvement has been less than was initially hoped for or intended.

The Board is asked to consider what is required from these sessions and what it wishes to see for future Board meetings.

**Duncan Long**
**Company Secretary**

# Questions from the Public for the Board

(Paul Burstow - Verbal)

# Any Other Urgent Business

(Paul Burstow - Verbal)

# Meeting Reflections

(Paul Burstow - Verbal)

# Date of Next Board Meeting in Public -

# Thursday 29 Sept 2022 9.00am

(Paul Burstow - Verbal)